THE NURSING PROFESSION AND GRADUATE STATUS IN ENGLAND: PERSPECTIVES FROM STUDENT NURSES AND HEALTH PROFESSIONAL EDUCATORS

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Abstract

This study investigates all graduate entry to nursing in England, focusing on the perceptions and experiences of nursing students and health professional educators at one English university. It presents a history of nurse education, debates the cases for and against the move to an all graduate entry, and introduces a conceptual framework based on the influences on, and expected outcomes of, the undergraduate nursing student. The study adopts a single-embedded case study design. Data was collected between October 2012 and September 2014 using questionnaires and focus groups. Statistical analysis and thematic analysis (using the framework devised by Braun and Clarke, 2006) were undertaken on the quantitative and qualitative data respectively. The undergraduate student nurses reflected a positive attitude towards nursing, seeing a therapeutic relationship and the values underpinning 'compassion in practice' as fundamental to the role of Registered Nurse (RN). They also demonstrated motivations that reflected these principles and, to some extent, recognised them in themselves. The importance of developing and demonstrating graduate attributes was acknowledged, but these were not seen to be as significant as the fundamental principles of what it means to be a nurse. The majority of health professional educators supported the move to an all graduate entry to nursing, with nurse educators being more in favour that their Allied Health Professional colleagues. There was also clear recognition that the role of the RN had changed and that RNs needed graduate attributes in order to manage the complexities of twenty-first century healthcare. Participants in this study saw the move to all graduate entry as welcome and necessary, although this view was not universal. Reasons students gave for pursuing a career in nursing reflected those identified in earlier studies. The students' experiences in clinical practice were affected by the standards of care they observed, the quality of mentorship and by issues related to 'belongingness'. The study highlights and contributes to the on-going debate surrounding the development of nursing as a profession, confirming that the ideals of altruism have not been lost in the development of academic processes and identity.

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Chapter 1: The history of nurse education in the United Kingdom

1.1 Introduction

> Ever since the formal training of nurses began during the latter part of the 19th century, there has been controversy. How much, what type and what level of education does a nurse need?
>
> (Castledine, 2009, p.1425)

On the 12 November 2009, following a two-year consultation run by the Nursing and Midwifery Council (NMC) where over 3000 individuals and organisations from around the United Kingdom (UK) responded (NMC, 2010a), Ann Keen MP, Parliamentary Under-Secretary of State for Health at the time announced at the Chief Nursing Officers' Summit that all pre-registration nurse education programmes would become degree level by September 2013 (Bowcott, 2009; British Broadcasting Association (BBC), 2009; Department of Health (DH), 2009). The minimum academic qualification permitting entry to the NMC register in England at the time was the Diploma of Higher Education (DipHE). According to the Royal College of Nursing (RCN, 2010) around 25% of nursing students in England were undertaking an honours degree with another 24% undertaking a non-honours degree or advanced diploma. The remaining students were undertaking a DipHE. In 2010 in Northern Ireland and Scotland around 80% of nursing students were on an undergraduate programme. In Wales, the degree had been the only entry-level qualification to the NMC register since 2004 (RCN, 2010).

According to Brooks and Rafferty (2010), the decision to require degree level nurse education signalled the end of a long struggle for those desiring parity with other healthcare professions, a struggle that began over a century before when, in 1889, Mrs Bedford Fenwick stated that nurses needed to be taught within higher education (Burke & Harris, 2000). The purpose of this chapter is to present a brief history of nurse education in the UK and, in doing so, provide some historical background to the change in question. As such the focus is on the history of nurse education and not a history of nursing, although the two are inextricably linked. Historical texts and other resources have been utilised and it is noted that different writers took particular approaches to interpreting the history (Bradshaw, 2013). Work from historians such

as Abel-Smith (1960), Baly (1997), Bradshaw (2001a) and Seymer (1957) are utilised, but the focus is on their account of nursing history and not on the epistemological approach of each author.

1.2 The origins of nurse training

The origins of nurse training in the UK can be traced back to the mid-1800s (Ousey, 2011). Prior to this across medieval Europe religious orders were responsible for what, nowadays, would be described as 'health and welfare' (Bradshaw, 2001a). The religious revival of the nineteenth century influenced the development of several 'nursing orders', one major example being the *Institute of Nursing* established by Elizabeth Fry in 1840 (Bradshaw, 2001a). Bradshaw (2001a) suggests that although the religious orders produced women of, "unblemished character," (p.3) these nurses lacked technical proficiency and underpinning theoretical knowledge. Nursing care was also undertaken by two other groups of women. Firstly the 'ladies' - women who were 'respectable' characters but who had a sentimental view of nursing, and were, "entirely incompetent," (Bradshaw, 2001a, p.3). Secondly there were the,

> Uneducated domestic servant nurses, the usual type of lay nurse in British hospitals, who could be morally weak and had low technical skill.
>
> (Bradshaw, 2001a, p.3).

Some authors credit Elizabeth Fry with establishing the first British nurse training school in the 1840s (Ford, 2010; Huntsman, Bruin & Holttum, 2002). However, popular opinion suggests Florence Nightingale (perhaps influenced by Elizabeth Fry) established the first training school for nurses in the UK at St Thomas's Hospital, London in 1860. Funding for this was raised by public subscription because of gratitude for Nightingale's contributions during the Crimean War (1854-1856). Nurse training began at the Nightingale School with the first fifteen students, then known as probationers, commencing their one-year programme on 09 July 1860 (London Metropolitan Archives, 2010; Seymer, 1957). The Fund paid for the probationers' salaries. After this first year of training, the probationers gained a further two years' experience on the wards at the hospital. One of Nightingale's goals was to challenge

the general attitudes at the time that suggested that all women, especially those with a religious persuasion such as deaconesses and nuns, could 'nurse' by instinct.
Bradshaw (2001a) suggests that Florence Nightingale's approach to nursing, and therefore to nurse training, was shaped by two main influences, her religious faith and her experiences at Kaiserswerth where she worked for three months in 1851. Kaiserswerth, situated a few miles from Düsseldorf, Germany was the location of the Protestant Institute of Deaconesses. The Institute was founded in 1833 by Pastor Theodore Fliedner initially as a home for female ex-convicts following their release from prison. By the time Nightingale worked there it had grown to include a hospital, an asylum, an orphanage and two schools (Abel-Smith, 1960). It was during her time at Kaiserswerth that Nightingale became convinced that nursing depended on moral motives (love rather than money) for the maintenance of quality and standards (Bradshaw, 2001a).

Florence Nightingale saw the development of character and self-discipline as the main purpose of nurse training. These were considered more important than academic ability (Baly, 1997). She was utterly convinced that nursing was a vocation – much wider than a religious calling from God. Religious faith was not an absolute requirement, but it was an essential background with a great deal of importance placed on 'character'. Nurses should be disciplined, restrained and obedient – carrying out the orders of the doctors and the requirements of the matron and sister without question (Davies, 1977). Character was far more important than 'book-knowledge' and the nurse deficient of these characteristics was rendered, in Nightingale's opinion, useless (Bradshaw, 2001a). According to Davies (1977) these characteristics made sense at the time as they were not a threat to doctors, served to attract middle-aged recruits and represented an attack on the prevailing image of nursing. Nightingale considered nurse training to be subordinate to nursing service. New students, under the close control of the matron provided a very useful and obedient workforce (Davies, 1977).

Nurse training at St Thomas's Hospital towards the end of the nineteenth century consisted of three main aspects. There were ward instructions given by the ward sister, lectures by medical staff supported by the Home Sister's tuition on nursing and

moral matters, and the taking of casebook/notes including the keeping of diaries (Baly, 1997). The diaries were used for recording the manner and amount of training an individual nurse received (Bradshaw, 2001a).

The initial years of training at St Thomas' Hospital along with Nightingale's view of nursing practice and nurse training were not without criticism. Cook and Webb (2002) highlight some of the early reactions from both the nursing and medical professions to Nightingale's reforms. Many were satisfied with the way things were and were apprehensive regarding the changes that Nightingale was introducing. There were concerns expressed that the changes were a serious threat to patient management (Cook & Webb, 2002). Baly (1997) concludes that the Nightingale School did not achieve much during the first ten years but acknowledges the School did attract recruits who, under the direction of Nightingale and backed by the Fund, established training schools elsewhere. Bradshaw (2001a) acknowledges the criticisms directed at Nightingale and her training school, but concludes that the principles she developed became the norm within nursing and nurse training for many years. Similarly, Abel-Smith (1960) suggests that whilst it would be a mistake to propose that Nightingale alone was responsible for the reforms to nursing, or even assume the training School she started at St Thomas's Hospital was indeed the first, her reforms were the most influential.

1.3 Registration

Towards the end of the nineteenth century, debate centred on the issue of nurse registration. The matter had been raised as early as 1874 by Sir Henry Acland, Regius Professor of Medicine at Oxford (Bradshaw, 2001a). Those in favour of nurse registration included Mrs Bedford Fenwick, matron at St Bartholomew's Hospital, who in 1887 founded the Royal British Nurses' Association, and Catherine Wood, matron at the Great Ormond Street Hospital. Those opposed included Florence Nightingale, not least because she did not believe that nursing could be tested by written examination. Nightingale, despite her deep convictions against registration, remained distant from the political campaign, though she did recognise that her name was often mentioned as a 'final authority' (Bradshaw, 2001a). However, Davies (1977) suggests that Nightingale succeeded in blocking any support for the campaigners from the UK

Parliament. Abel-Smith (1960) points to Nightingale's many friends in nursing and politics, suggesting that her views were indeed influential. Abel-Smith (1960) also argues that Nightingale was able to impose her views on the matrons at several hospitals (matrons who had possibly trained at the Nightingale School of Nursing and worked at St Thomas' Hospital) who in turn were able to impose this view on the nurses working at their hospital, confident that their instructions would be implemented without question. A bitter dispute followed, with several publications in journals such as the *British Medical Journal*, the *Lancet* and the *Nursing Record*. Coinciding with the founding of the Royal British Nurses' Association in 1887, the General Medical Council passed a resolution in favour of certification of competently trained nurses (White, 1976). The Matrons' Council was established by Mrs Bedford Fenwick in 1894, with one of its main objectives being the registration of nurses. Further resolutions were passed by the British Medical Association between 1895 and 1906. In 1903 a Bill for the registration of nurses was presented in the House of Commons, but proved unsuccessful. Several more Bills regarding nurse registration were brought before Parliament prior to the outbreak of World War One in 1914 when any unnecessary legislation was deferred (White, 1976). Ultimately those in favour of registration succeeded and the Nurse Registration Act was passed in 1919, despite intense debate and bitter disputes (Davies, 1977). According to White (1976) much of the delay was because of a lack of agreement within the nursing profession itself over the need for and the principles of registration, as well as a problem in defining a 'nurse', and therefore 'nursing'. Nonetheless, the Bill led to the creation of the General Nursing Council (GNC) (White, 1976; NMC, 2010b) which remained in place until 1979 when further legislation led to the development of the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC) and the National Boards (NMC, 2010b). The impact of registration on nurse education was immediate. The first council of the GNC drew up a draft schedule for the approval of all nurse training schools, set a general standard of education for nurses which was distributed to all hospitals, and provided information on a proposed syllabus of lectures and demonstrations for general nurse training (White, 1976). Davies (1977) argues that the advent of registration saw the beginning of the influence of another party on the development of nursing and nurse education: the UK Government. Indeed, Abel-Smith (1960) suggest that most decisions taken regarding the implementation of the

Nurse Registration Act were taken by the Minister for Health or the House of Commons rather than the GNC.

It appears that despite the social changes brought about by the First World War, and despite Nurse Registration and the development of the GNC, Florence Nightingale's vision of nursing as art and science, of theory and practice, and of the apprenticeship model was so fundamental to the profession that it was almost sacrosanct. What was not disputed was that there was a scientific or technical element to nursing. What was disputed was the amount of emphasis that should be placed on the scientific and technical (Bradshaw, 2001a).

1.4 A national approach

The first national syllabus for nursing was developed during the early 1920s, based largely on Florence Nightingale's principles. What nurse training schools had been doing on an individual basis, i.e. deciding the length and content of the training, became a national syllabus for a three-year apprenticeship programme (Bradshaw, 2001a).

Debate during the 1930s centred mainly on the shortage of nurses, pay and conditions and the possible impact of the continued view that nursing was a vocation. The Lancet Commission was established in 1930 to examine some of these issues. The Lancet Commission Report was published in 1932, and amongst the conclusions were, "the standards of the profession could not be maintained purely by economic appeal," (cited in Abel-Smith, 1960, p.136), confirming the view of many that there remained a vocational rather than financial attraction to nursing (Bradshaw, 2001a). However, the Athlone Committee Report published in 1939 concluded that a sense of vocation was not sufficient and therefore pay and conditions needed to be improved to ensure nursing competed with other careers open to women (Bradshaw, 2001a).

The outbreak of World War Two in 1939 led to further shortages of trained nurses (Hallam, 2002). The Royal College of Nursing (RCN) set up the Horder Committee in 1941 to consider and implement the recommendations from the Athlone Committee and suggest any amendments required due to the outbreak of war (Bradshaw, 2001a).

Horder rejected a view expressed by a section of doctors, who argued that nurse training was becoming too theoretical, with the risk of producing 'pseudo-doctors' (Bradshaw, 2001a). The Horder Committee recommended the retention of the apprenticeship model, but called for trainees to be given student status. The trainee should be considered a student first and an apprentice second. The committee also recommended that an honours degree programme be established for the brightest students (Bradshaw, 2001a). Nursing was still viewed as one of very few 'respectable' occupations for women and the introduction of the non-academic State Enrolled Nurse qualification, a two year, practical training programme set up in 1943, was an attempt to make nursing available to women without any educational qualifications in the hope this would help alleviate the chronic shortage (Hallam, 2002).

The Committee on the Recruitment and Training of Nurses chaired by Sir Robert Wood was established in 1947 to consider the impact that war had had on nursing and to prepare nursing for the impending launch of the National Health Service (NHS). Many of this committee's recommendations were similar to those from the Horder Committee, suggesting little had actually changed during the early 1940s. The recommendations included an improvement in working conditions for all nurses and a reduction in working hours. The report also concluded that the apprenticeship model was low in status and was redundant (Bradshaw, 2001a), recommending that nursing students be given both full student and supernumerary status (Davies, 1977; RCN, 2012). In short, the report suggested the separation of training from service, attacked the element of routine, repetitive tasks in nurse training, and stressed a more academic approach (Davies, 1977). It also recommended that students should not be involved in 'domestic chores' and thus, training should be reduced from three years to two. Most stakeholders including the RCN, the GNC and the Kings Fund did not agree with many of the report's recommendations and as a result, they were not widely accepted (Bradshaw, 2001a; RCN, 2012). As Bentley (1996) concludes, the recommendations did not coincide with the needs of the hospitals or the views of nurse leaders at the time. Nursing itself re-affirmed Nightingale's principles where a three-year training (the proposed reduction to two years was widely condemned) was, "less to do with a complex content of work, and more to do with fulfilling the service needs of the hospital and creating a humble and disciplined character in the nurse," (Davies,

1977, p.488). Ultimately, the concept of student status was accepted by the GNC in 1948, but the student nurse remained part of the ward establishment (Abel-Smith, 1960; Bentley, 1996).

1.5 University-based programmes

In 1959, nine students commenced a four-year programme at the University of Manchester that would, if successfully completed, mean they would qualify as State Registered Nurses, Health Visitors and have a Diploma in Community Nursing. These students were amongst the first to undertake a nurse education programme at a UK university (Hallett, 2005). Other universities such as Edinburgh, Southampton and Surrey were establishing similar programmes creating the link between nursing and higher education that had first been called for by Mrs Bedford Fenwick in 1889 (Burke & Harris, 2000; Owen, 1988). Several of these programmes were at undergraduate level (Owen, 1988) with the first reportedly commencing at the University of Edinburgh in 1965. Several universities offered a degree 'with' nursing rather than 'in' nursing (Burke & Harris, 2000). The first degree programme in the Commonwealth had been established in Canada, at the University of British Columbia in 1919 (Bramadat & Chalmers, 1989) and the first in the United States of America (USA) had been established the same year at the University of Minnesota (Brooks & Rafferty, 2010). According to Brookes and Rafferty (2010) the first meaningful discussions in the UK regarding a nursing degree programme had taken place, courtesy of the RCN Education Committee, in 1944. The Committee considered the possibility of a degree in Nursing at the University of London, but the plans were shelved.

1.6 The Platt Report

The RCN convened another committee in 1961, and asked Sir Henry Platt to chair it (Bentley, 1996). The Platt Report was published in 1964 with recommendations similar to those from the Wood Report regarding the fact that nurse training should be based on sound educational principles. The Platt Report went further though, suggesting that training should be governed by the students' educational needs, not service requirements, and during the first two years of training students should be financially independent of the hospital (Bentley, 1996). The Platt Report also recommended that the standard entry to nurse training should be the General Certificate of Education in

five subjects at Ordinary level (Ousey, 2011). The Platt report was rejected by the GNC, not least because of the views of hospital managers and their concerns over workforce numbers (Bentley, 1996). In addition, one influential matron feared the recommendations would not lead to a 'practical nurse'. Technical skills were important but the, "milk of human kindness," should not be lost (Bradshaw, 2001a, p.155). The GNC also questioned the move away from the vocational ethos of nursing (Ousey, 2011), however, they did recommend that further steps be taken to explore the possibility of developing undergraduate programmes in nursing to help retain the academic 'high-flyers' who may otherwise be lost to other professions (Bradshaw, 2001a).

1.7 The Briggs Report

The Briggs Report, commissioned by the Labour Government in 1970 was published in 1972 (Briggs, 1972). The terms of reference for Briggs were to review the role of the nurse and midwife, and the education and training required to meet that role. The main assumption was that the Florence Nightingale tradition was outdated. Key recommendations included the setting up of a single central body responsible for professional standards, education and discipline, the establishment of Colleges of Nursing and Midwifery, and the establishment of an eighteen-month basic course for all entrants, leading to a Certificate in Nursing Practice. A further eighteen-month course would lead to registration. The Briggs Report also recommended that students should be recruited from a wide range of backgrounds, that special attention be devoted to recruiting more A-level, undergraduate and graduate students, and that nursing should become a more research-based discipline. According to Ousey (2011) the recommendations were not implemented until some five years later, as the basis for the Nurses, Midwives and Health Visitors Act (HMSO, 1979). Student status continued to be an unresolved issue. It was not until the development of Project 2000 that the term 'supernumerary' was introduced as the supernumerary student finally replaced the apprentice (Bradshaw, 2001a).

The UKCC was established in 1983 to maintain a register of UK nurses, midwives and health visitors, provide guidance to those on the register and to handle professional misconduct complaints. The UKCC continued until 2002 when it was replaced by the

Nursing and Midwifery Council, which remains the regulatory body for nursing in the UK (NMC, 2010b). The launch of the UKCC in 1983 coincided with the launch of separate Nursing Boards for each of the UK countries (NMC, 2010b), another recommendation from the Briggs Report (1972).

1.8 The end of the 'School of Nursing'

The move from the schools of nursing in the hospital setting to the higher education institutions (HEIs) was initiated by the Judge Report, published by the RCN in 1985 (Ousey, 2011; RCN, 2012). According to the UKCC (1986), one of the key factors influencing the setting up of the Judge Committee was the delay in implementing some of the key recommendations from the Briggs Report. The Judge Report also recommended the establishment of a three-year course comprising of a foundation year, a second year in adult nursing and a third year in a speciality (Ousey, 2011). During 1985, the English National Board (ENB) published their recommendations for nurse education and training, which included the establishment of supernumerary status for students and a common core programme leading to specialisms (Ousey, 2011). Both the Judge Report and the ENB consultation paper were published during the time of the UKCC project which would culminate in their recommendations for changing nurse education (UKCC, 1986). The UKCC (1986) project report '*Project 2000: A new preparation for practice*', endorsed the recommendations from the Briggs Report of some fourteen years earlier in relation to the move away from hospital-based schools of nursing to HEIs. Other recommendations included the establishment of supernumerary status. Remuneration would be via training grants, controlled by the NHS. Courses should be converted from certificate to diploma level and students should complete an initial 'common foundation programme' of eighteen months, then specialise into one of five branches: adult; child; mental illness; mental handicap (now learning disability) or midwifery (now a separate programme). The UKCC (1986) also recommended that teachers of nursing, midwifery or health visiting should be graduates and have a formal teaching qualification, and clinical staff involved in the teaching of students should be formally trained to undertake this role.

The UKCC (1986) additionally recommended that training programmes which led to Enrolled Nurse registration should cease, with current ENs given the opportunity to

follow a programme of additional training to Registered Nurse (RN) status in their chosen branch. The over-riding aim of Project 2000 was to produce a '*knowledgeable-doer*', able to, "marshal the relevant information to make an assessment of need, to devise a plan of care consequent upon that assessment, to implement, monitor and evaluate it," (UKCC, 1986, p. 40). The RN must be a, "thinking person with analytical skills," (UKCC, 1986, p.40). The first Project 2000 courses began in 1989 (Bentley, 1996) and their introduction radically transformed the way nurses were educated and prepared for professional practice (Fulbrook, Rolfe, Albarran, & Boxall, 2000). By 1995-96 all schools of nursing within the UK had integrated into higher education (Burke, 2003; Deery & Philips, 1998). Watson (1998) recognised that most nursing education programmes were, at the time diploma level, but some of the general principles of Project 2000 were also available in degree programmes. Watson (1998) also noted that nurse lecturers teaching on nursing degree programmes at the time were not universally in favour of the implementation of Project 2000, voicing concerns about educational coherence, whilst others suggested that such educational programmes may detract from the caring role of the nurse. Evidence suggested that Project 2000 provided nurses with a sound knowledge base who were, "better able to adapt to change and implement evidence-based practice than those trained under the old, apprenticeship style model," (UKCC, 1999, p.4). Carlisle, Luker, Davies, Stilwell and Wilson (1999), as part of their study involving nurse managers and their perceptions of skills competency amongst newly qualified nurses, identified that many managers indicated that these nurses did possess research knowledge and the ability to undertake care planning. Project 2000 was not without its critics, not least due to the weighting of the theoretical over the practical; the initial eighteen-month theory, with little or no exposure to a clinical setting, and (perhaps as a result) the lack of clinical skills of newly qualified RNs (Carlisle *et al*., 1999; Fulbrook *et al*., 2000; Glen & Clarke, 1999; Higgins, Spencer & Kane, 2010; Merrabeau, 2004; UKCC, 1999).

Immediately prior to the release of the Peach Report, *'Fitness for purpose'* published by the UKCC (1999), which reviewed nurse education, particularly in relation to Project 2000, the Labour Government published *'Making a Difference'* (DH, 1999). This Report set out the Government's strategic intentions for nursing, midwifery and health visiting. The *'Making a Difference'* Report suggested that students completing the

Project 2000 course were not equipped at their point of registration with the full range of clinical skills required, a point raised in the Peach Report too. No hint was made of what this full range of skills entailed, but the suggestion was that remedial action could be taken quickly and that action must include increased practical orientation embedded within the new proposed programme. '*Making a Difference'* also proposed strengthening the links between vocational training and pre-registration nursing. The plan was to make pre-registration nurse education accessible to mature students who had spent time working as a health care assistant. A new short or 'fast-track' programme was to be designed for this purpose. The document also clearly articulated the fact that the Department of Health was to assume greater control for the education of nurses, both in design and direction. Arguably, part of this was a call for a more consistent approach to pre-registration nurse education, including a proposal of key outcomes to be achieved at the end of each of the usual three years of the programme. In short, the then (1999) Labour Government's key priorities for nurse education were:

- To establish stronger links between the NHS and universities
- To ensure that nurse education was more responsive to the needs of the NHS
- To increase the emphasis on the 'practical skills' within pre-registration nursing programmes
- To widen access to nurse education (in line with a policy of increasing access to Higher Education more generally) and more flexible career pathways into and within nursing

The Peach Report (UKCC, 1999) suggested that an increasing number of HEIs were offering DipHEs in Nursing which included some degree level credits. As such, included within Recommendation 8, that there be an expansion of graduate programmes for nursing, was the justification that there already existed a close approximation between the current diploma and graduate level preparation. The Peach Report confirmed the importance of the role of the mentor and the support they offered the student nurse in clinical practice, but called for a more consistent and formal approach to the preparation of mentors. At the time of publication of the Report, there were wide variations in attrition rates for pre-registration nursing programmes; 5% to 30%. The Report suggested that some of the reasons for the higher levels of attrition were a lack of support in clinical practice and difficulties travelling to and from

clinical placements. *'Making a difference'* also recommended establishing a smaller UK-wide council to replace the UKCC and the four National Boards. This was achieved in April 2002 with the establishment of the NMC.

1.9 Conclusion

The education and training of nurses has been the subject of much debate and on-going change since the first training course was established in the late nineteenth century. Key to much of the change and debate has been the balance between the educational requirements of the student/trainee and the workforce requirements of health-service practice, predominantly, the NHS. The 'level' of educational requirements for the student has also been a substantial factor and the tenet to make the preparation of nursing students more of an 'academic education' rather than an apprentice-style training. This led to the move to HEIs towards the end of the 1990s and subsequently, the move to an all graduate entry to nursing. Few, if any of these changes have been met with universal approval.

Chapter 2: The case for and against the move to an all graduate entry to nursing: A critical debate

2.1 Introduction

The decision to move to an all graduate entry to nursing in England was a significant development to the preparation and education of nursing students. Despite this decision being over a century in the making (Brooks & Rafferty, 2010; Burke & Harris, 2000), when it arrived it generated a great deal of debate both within and without the nursing profession (Ali & Watson, 2011). This chapter seeks to summarise some of these discussions in the form of a dramatized 'spoken' formal dialogue debating the move. Papers and editorials used to support the cases for and against the move were identified primarily from academic sources published between 01 January 2000 and 31 December 2012. These dates were chosen as they covered the time between the move of pre-registration nurse education in England into higher education institutions (HEIs), seen by some as a pre-cursor to the decision to move to all graduate (Debell & Branson, 2009), and the implementation in many HEIs of the first all graduate programmes. Newspaper articles were not used as primary sources but critical analyses and reviews of such articles, for example by Gillett (2012) were utilised.

2.2 The motion

The move to an all graduate entry to nursing is required in order to equip Registered Nurses (RNs) to manage in an increasingly complex and diverse healthcare setting.

2.3 First speaker for the motion

This move is very welcome and will ensure the on-going development and recognition of nursing as a profession in its own right. It is high time that nursing moved away from the quite frankly outdated and condescending stereotypical image of 'hand-maiden' who blindly follows the doctor's orders (McKenna, Thompson, Watson & Norman, 2006; The Prime Minister's Commission, 2010).

Ali and Watson (2011, p.313) recognise the dilemma facing nursing when they state,

> On the one hand, nurses are expected to provide the best evidence-based care to their patients; on the other hand, they are expected not to have the knowledge and skills (by opposing degree-level education) that enable them to use current evidence. Such attitudes substantiate

> that nurses are still seen in the role of handmaidens. They are expected to obey and carry out orders, and keep themselves busy with basic care needs of patients.

The move is therefore welcomed as England has procrastinated whilst other parts of the United Kingdom (UK) and many developed countries across the world have moved to an all graduate entry (Mitchell, 2008; Robinson & Griffiths, 2007; Taylor, Irvine, Bradbury-Jones & McKenna, 2010). It is also welcomed to ensure that the education and preparation of nursing students is at a comparable level to other allied health professions (Chan, 2013; The Prime Minister's Commission, 2010). Inter-professional working is part of modern healthcare and nursing must be considered comparable to and commensurate with these other allied health professions. The move of these other professions to degree level preparation was not met with the same level or intensity of opposition as has been the case with nursing (Burke, 2006). Why that is probably stems back to the historical view that 'care', seen as a fundamental aspect of nursing, is 'women's work' (Kenny, 2004; Meerabeau, 2004), where character and personality are far more important than intellectual ability (Birchenall, 2003). However, as Griffiths, Speed, Horne and Keeley (2012, p.126) suggest, "there is arguably nothing simple about 'caring'."

The motion highlights the changing nature of healthcare. Many writers support this and acknowledge that the only way to prepare nurses to deal with the challenges of twenty-first century healthcare is at undergraduate level (Ali & Watson, 2011; Hartigan, Murphy, Flynn, & Walshe, 2010; Kinnair, 2010; Mitchell, 2008; NMC, 2010c; RCN, 2012). Why is this? For a start, according to Girot (2000a) degree level nurses are better decision-makers. In her study, Girot (2000a), identified that academic level was more of an influence on decision-making and searching for alternatives than was experience, although experience did enhance these skills in the graduate nurse too. Evidence also indicates that graduate nurses make a significant difference to patient care. Aiken, Clarke, Cheung, Sloane and Silber (2003) in a cross-sectional analyses of outcomes data for 232,342 surgical patients discharged from 168 hospitals in Pennsylvania and survey data from 10,184 nurses identified mortality and failure to rescue rates were lower where there was a higher percentage of nurses, trained to baccalaureate level or above. The authors conclude that for every 10% increase in

the proportion of nurses with higher degrees there was a decrease in the risk of mortality and failure to rescue by a factor of 0.95 (or by 5%, after controlling for patient and hospital factors) (Aiken *et al.*, 2003). Although the study was based in one US state only, the results are clearly significant. The study also concluded that a nurse's years of experience was not a significant predictor of mortality and failure to rescue levels – a degree matters! A UK based study by Bartlett, Simonite, Westcott and Taylor (2000) identified that degree-trained nurses were more competent following their graduation than were their diplomate counterparts.

Ali and Watson (2011, p.314) state,

> Evidence suggests that degree-prepared nurses are better equipped to hypothesize, critically analyse, reflect and identify their learning needs; use evidence-based practice; work creatively and innovatively; challenge existing practices; and bring about and manage change.

Mckendry, Mckay, Boyd and Andrew (2012) suggest that these skills are taught within the academic setting and are 'graduate attributes'. If it is agreed that these skills are required, then it follows that a degree obtained in an academic institution is the best way to acquire them. Why would anyone not see these attributes as beneficial and in the best interest of patients/service users and their families? Contrast this with Castledine's (2009) reflections of his own 'apprenticeship' training where he was, "trained to watch what went on around me, and to know all the answers based on ritual and routine," (p.1425). Castledine became what Greenwood (2000) would describe as a 'doer' rather than a 'thinker'. Swindells and Willmott (2003) in their study involving nursing diplomates and graduates from the University of Nottingham identified that a degree added value to practice; graduates had higher cognitive ability, higher reflective practice ability and higher levels of professional practice. Graduate status also promotes the ethos of lifelong learning (Debell & Branson, 2009; Greenwood, 2000; Steur, Jansen & Hofman, 2012). If healthcare is changing, and the evidence base continues to develop, then it follows that those working in healthcare should adopt a lifelong learning approach to their own personal and professional development.

2.4 First speaker against the motion

The move to an all graduate entry is completely unnecessary. Let us not forget that nursing is a vocation and the main argument against graduate education is the fact that having a degree does not necessarily make a good nurse (Ali & Watson, 2011; Burke & Harris, 2000; Meerabeau, 2004). The first speaker offers some rationale for the move, including a study by Bartlett *et al.* (2000) as evidence of an increased level of competence amongst graduates. Firstly, the authors acknowledge that the degree programme was four years in length compared to a three-year diploma programme; a longer programme is certain to offer more opportunities to become 'more competent', and secondly, there was no significant difference in competence on qualifying – the difference was noted some six-months post-qualification. So, students who spent a year longer on a programme were no more competent on qualification. A similar study by Clinton, Murrells & Robinson (2005), also based in the UK, identified no significant difference in the perceived levels of competence between diplomates and graduates.

The first speaker talks about the level of opposition that there has been to the move. It is fair to say that much of this has been generated from within the nursing profession itself (Brooks & Rafferty, 2010). Current and former nurses have been voicing their opposition to the move for many years. What better group of people is there to give a reasoned and knowledgeable argument against this change? They *are* the nurses working in twenty-first century healthcare environments. To broaden this argument out a little, in the study by Burke and Harris (2000) involving 34 key stakeholders concerned with the commissioning and contracting for education, only three thought nursing should be an all graduate profession – hardly a ringing endorsement! The participants felt that graduates were unlikely to be willing to undertake some of the more basic nursing duties – I do not like the word 'basic' here as it gives the impression that these duties are unimportant and can be done by anyone; the term 'essential' is far more preferable as it reflects the vitally important nature of this work. In addition, some of the participants in Burke and Harris's (2000) study were concerned that the increased academic entry requirements would prevent many potentially excellent nurses from applying. This is a concern expressed by many others and reported in a number of studies and papers (Debell & Branson, 2009; Gillett, 2012; McNamara, 2008; Mitchell, 2008). At a time of nursing shortages, where across the UK hospitals

are once again recruiting RNs from abroad it seems ludicrous to reduce the possible number of pre-registration nursing applicants by shifting the 'academic requirements' to such unnecessary levels.

The argument in favour of parity with other health professionals is interesting. When we really get to the crux of the issue, this is about the nurse-doctor relationship, isn't it? The 'new nurse' wanting a high level of decision-making and autonomy. Well, many nurses, as Clarke (2004) suggests, do not see an issue with working with and taking direction from medical staff. The goal that these 'new nurses' will be better critical thinkers is quite frankly an anathema to what many see the role of the nurse to be. Yes, a nurse needs to know what they are doing, they need to practice safely, and recognise and report unsafe practice - this is enshrined in the Code (NMC, 2008) which incidentally, makes no distinction at all for academic qualification. Nursing is first and foremost about patient care, getting alongside an individual and their family, not being so academically minded that they are no practical good. This was a point raised by patients/service users and their families in the study by Griffiths *et al.* (2012) based in the northwest of England. The study identified that participants did acknowledge that nurses needed to be knowledgeable and competent, but they prioritised qualities such as empathy, listening skills, being non-judgemental and offering individualised care. The participants expressed concerns that these 'essential elements' were being marginalised as nursing became more 'academic'. As McEwan (2003) argues, degree level education may be okay for physiotherapists and occupational therapists, but that does not mean nursing should follow suit. Each profession is unique.

There remains the accusation that graduate nurses are not adequately prepared for clinical practice (Hartigan *et al.*, 2010). It is surely more prudent to stop worrying about the academic level and start examining more closely individual curricula to make sure that nurses today are 'fit for practice' in the twenty-first century. Nursing is essentially practical, not theoretical. By making the preparation of nurses all graduate, the theoretical is over-emphasised and the practical undermined. The new 'balance' of theory and practice is the wrong way round.

2.5 Second speaker for the motion

Why is it that nurses themselves seem to be the most vociferous group against the move? It is true that under the apprenticeship approach students learnt at the bedside, but the priority was the needs of the service and not their education. They were there primarily as 'cheap labour' (Burke, 2003; Greenwood, 2000). It should be emphasised that pre-registration nursing programmes within the UK are a 50:50 split between theory and practice (NMC, 2010c), as they have been for many years. The move to an all graduate entry has not led to an increase in the theoretical element and a commensurate reduction in the practical. The last speaker highlighted concerns that the move will prevent some potentially excellent nurses from applying. As Watson and Shields (2009) ask, who are these good nurses the profession is going to lose? They provocatively add,

> We are sure that we are preventing many, potentially, 'good neurosurgeons' from becoming neurosurgeons by insisting that they earn a medical degree and, subsequently, an appropriate surgical fellowship. How much easier it would be for them and how much it would benefit the general population if we were able to set these 'good people' on the course to removing blood clots from the brain and suturing sub-arachnoid blood vessels through an apprentice-style training. After all, surely neurosurgery is just about manual dexterity?
>
> (Watson & Shields, 2009, p.2925)

Rather than reduce recruitment the move to an all graduate entry may well increase it by making nursing a much more attractive career choice (Ali & Watson, 2011). Recruitment may well be different (Debell & Branson, 2009), but not necessarily in a bad way. Mitchell (2008) suggests that the move to an all graduate entry to nursing in Wales did not result in a reduction of applicants. Indeed, Debell and Branson (2009) identify that recruitment figures for teaching and social work increased when these disciplines moved to all graduate entry to the workforce.

Ali and Watson (2011) include in their paper a quote from Christine Hancock, former General Secretary of the Royal College of Nursing, in which she states that there is no evidence to indicate those who are better educated are any less caring or competent. Gillett (2012) agrees, and we must settle once and for all the perceived

dualism between care and compassion on the one hand and academic ability on the other. They are not mutually exclusive. If having a degree does not necessarily confirm a 'good nurse', neither, it must be said, does not having a degree. Nursing must accept, as Ali and Watson (2011) acknowledge, that there will be diploma trained nurses who can work in complex situations, utilising excellent leadership skills and basing their clinical practice on current evidence, just as there will be graduate nurses who do not practice at this level, but these are individual cases. No-one is arguing against the need for nurses to be compassionate and caring, but as The Prime Minister's Commission (2010) stated, compassion alone is not enough. Nurses must be educated to deliver safe, effective, compassionate and competent care. Let me make myself absolutely clear here. I am not suggesting that non-graduate nurses are incompetent or unable to deliver safe practice. What is being argued is how best the current and future generation of nurses are prepared to deliver the best possible care, whilst promoting the essential professional values of nursing itself.

The point about graduates not being adequately prepared for clinical practice is noted, but firstly, were they ever, and what 'practice' are we preparing them for? The Darzi Report (DH, 2008) highlights the need for a period of preceptorship to help enable the change from student nurse to RN. This is not a new issue and is not a result of the move to an all graduate entry. As Holland (2008) quite rightly acknowledges, the student nurses should be at a level where they can be considered as 'fit for purpose' but are not yet 'tried and tested' in their new roles as RNs. The Willis Commission into Nurse Education (RCN, 2012) makes a similar point suggesting that students being the 'finished article' at the end of their training, "could not be further from the truth," (p.5).

Healthcare is changing. As Macleod Clarke (2007) suggests, much of the care delivery is now undertaken by health care support workers. Nurses will be involved with essential and complex care but will supervise, advise and provide leadership. Indeed, Debell and Branson (2009) argue that if nursing is to be associated with improvements in outcomes for patients/service users, then it is essential that nursing students (and I would add, RNs) move beyond practice alone and provide the nursing workforce with strong leadership. They argue that degree level education is essential

for this. I would go further and acknowledge the musings of Betts (2006) and suggest that the goal of nurse education is not just to produce practitioners who can think, but thinkers who can practice – those who can see beyond the constraints of current practice.

Society must stop blaming the future generation of nurses for the current state of the National Health Service (NHS). As Gillett (2012) suggests, a sizeable lobby of anti-intellectual journalists seem to blame the increased academic nature of nursing education for the current problems within the NHS. The issues with and problems facing the NHS are varied and multifaceted and beyond the scope of this debate, but to suggest the blame lies at the feet of graduate nurses is, quite frankly, preposterous. The Willis Commission (RCN, 2012) concludes there were no major shortcomings in nurse education that could be held directly responsible for the widely-publicised decline in standards of care or stories of poor practice. If there is any blame, it lies with the 'providers' not the 'preparers'. I would also agree with The Prime Minister's Commission (2010) that the media have helped influenced the public perception of nurses and nursing, often suggesting that they are typically female and middle-aged (Meerabeau, 2004), work under the direction of medicine and clean up bodily waste (Turale, 2011). As the Prime Ministers' Commission (2010) stated, the public image of nursing is out of date. Nursing may not find it easy changing this out-dated image, but change it must.

As a last word, Watson (2002, p.480) states,

> How much better is the care of an older person with a pressure ulcer if the nurse understands the biology of the skin and wound healing? How much better if the advice to a newly diagnosed patient with diabetes if the nurse understands such things as locus of control? How much better is the health education of a family living in a deprived inner city area if the nurse understands the social effects of deprivation?

2.6 Second speaker against the motion

The speaker here talks a lot about how improved knowledge can result in better care. I am not going to dispute that, but I would question how such knowledge is gained. McEwan (2003) a Registered Nurse with over 20 years of clinical experience suggests real nursing knowledge is not gained from textbooks but through experience. Being involved in the daily interaction with patients/service users is how knowledge of nursing is gained, not by sitting and reading books and journal articles. She endorses many of the changes that have occurred in nursing, noting that nurses are now more autonomous than they have ever been, but still supports the need for nurses to not only 'know' but also to 'do', even if the 'doing' may simply mean 'being there' and holding a hand. A cursory search on journal databases for any topic in relation to nursing practice/care will reveal many hundreds of different articles all offering a different perspective. This highlights the over 'academicization' of nursing which turns what are quite simple concepts into a never-ending pursuit to 'prove' what we do does or does not work. Indeed, I would suggest that it often seems research in nursing is done for the sake of doing research, often in the pursuit of an academic qualification, not the improvement of patient/service user care. Let's face it, nursing has struggled to be accepted into academia and struggled to be recognised for its own research (Meerabeau, 2005; Watson & Thompson, 2004) so as a profession we need to accept that the research agenda has not been realised and nursing should go back to its core purpose – providing fundamental patient care. It is worth noting that according to the review of pre-registration nursing education undertaken by the NMC (Mitchell, 2008), only 29% of individual RNs were in favour of the move to all graduate entry compared with 61% of educationalists (and 55% for those working in a HEI). So, RNs who are currently 'doing the job' do not feel it is necessary, but the educationalist, many of whom will not have practiced clinically for years, support the move. I know who I think we should be taking more notice of! Indeed, a cynic might suggest that this ties in well with the 'research agenda' argument we have just discussed, and hints at job creation/protection for some academics.

The resolution suggested that a degree is required to equip nurses to manage in an increasingly complex healthcare setting. I would argue that however complex healthcare is becoming, the fundamental aspects of nursing remain just that –

fundamental and unchanging. Patients/service users and their families still need to feel 'cared for' by nurses who are first and foremost there because they want to nurse. How should these nurses be prepared for current healthcare practice? The statement 'practice makes perfect' has been used for many, many years. I would whole-heartedly agree. In other words, the best way to perfect the skills, knowledge and competence of student nurses is to expose them to the realities and complexities of clinical practice. This is where the real learning takes place, not in the relative comfort of the lecture theatre or seminar room.

[There ends the debate]

2.7 Concluding remarks

As Mcilfatric (2004) suggests, preparing nursing students for clinical practice is a complex task and there is no single, successful formulae by which this can be achieved. It is generally accepted that the education system must produce nurses who are academically educated *and* compassionate, not one or the other (McKenna *et al.*, 2006; RCN, 2012; Taylor *et al.*, 2010). The arguments presented above do offer a greater weighting to the cause for a move to an all graduate entry, highlighting the fact that there does appear to be more constructive and empirical evidence to support the move. Many of the arguments against are emotive and hark back to the 'good old days of nursing', a phrase used by McKenna *et al.* (2006) in their editorial written before the announcement of the move in England, but clearly referring to the benefits of graduate education for nursing. In addition, there is, at best, only anecdotal evidence to support the hypothesis that graduate nurses are less caring than their non-graduate colleagues (McKenna *et al*, 2006), an issue The Prime Minister's Commission (2010) suggested included, "many myths and misunderstandings," (p.4). What is clear is that the decision to move to an all graduate entry to nursing has not been met with universal approval. The decision has been made, but nursing must acknowledge the concerns raised by those against the move. The merits of the move to an all graduate entry, proposed by those instrumental in making the decision and by many in favour of the move may take some years to be fully realised (or not as the case may be). However, that does not mean aspects of the move are not open to investigation. The decision has been made, but it is still meaningful to investigate the

attitudes and experiences of academic nursing staff, who will be instrumental in delivering the new all graduate curricula. In addition, a silent voice in much of the debate for and against the move has been the nursing students who have chosen to pursue a career in nursing and therefore must apply for a degree programme. Their motives, drives, attitudes and experiences are rich sources of data as nursing takes the initial steps through this latest, and perhaps most significant change.

Chapter 3: Conceptual framework: All graduate entry to nursing

3.1 Introduction

Chapter one presented a history of nurse training/education and summarised the journey nursing has taken up to and including the move into higher education institutions (HEIs) in the late 1990s. Chapter two presented, through the device of a dramatized debate, some key arguments for and against the move to an all graduate entry to nursing. As discussed in chapter two, the move was seen as significant and did not meet with universal approval. Those in favour of the move highlighted amongst other positive impacts, the continued development of nursing, including its strive for a professional knowledge base. The undergraduate student nurse undertaking a degree in nursing in the United Kingdom (UK) is at the very heart of this development and, one may argue, will play a pivotal role in it. For this reason, the 'undergraduate student nurse' was central to the conceptual framework for this study (Figure 3.1). Theories linked with the framework include Situated Learning Theory (Lave & Wenger, 1991) and Social Learning Theory (Bahn, 2001; Bandura, 1971 and 1977), as well as an approach to understanding professional knowledge developed by Winch (2013 and 2014), considering the '*Sociology of professional knowledge*' suggested by Young and Muller (2014). This chapter presents the conceptual framework. The concept of the move to an all graduate entry to nursing is multifaceted and this framework does not set out to present all possible facets. The scope of the study led to the development of the conceptual framework rather than identifying a theory or theoretical framework that would provide the necessary guidance for the study.

3.1.1 What is a profession/professional?

Defining what a 'profession' is, and therefore what a 'professional' is can be difficult. Within the sporting arena, being a professional seemingly entails being paid for what you do; an 'amateur' being one who does not earn a living from their chosen sport. It may be that to be professional is to be considered an 'expert' or one who does a particularly good job (Cribb & Gewirtz, 2015).[1] Friedson (2001) focuses much of his attention on 'professionalism' which he suggests exists when an organised occupation gains the power to determine for themselves who is qualified to perform a set of tasks defined by the occupation, sets the criteria by which performance in undertaking these

tasks should be judged, and prevents 'others' from undertaking these tasks. The use of the term 'task' is interesting here and hints at 'mastery' of particular skills; an emphasis on the practical.

3.1.2 Is nursing a profession?

The struggles that nursing has had and continues to have regarding academic and professional recognition are well documented (McNamara & Fealy, 2014) and are multifactorial. In writing a definition for nursing, the Royal College of Nursing (RCN, 2014) indicate that nursing could be viewed as an activity, an occupation, a profession or a discipline. Writing from a historical perspective, Bradshaw (2001b) suggests that as nursing developed through the nineteenth and twentieth centuries it was considered as being both a vocation and a profession, the 'profession' element being rooted in the word 'profess' as an outward demonstration of an inward conviction. Bradshaw (2001b) includes a quote from Florence Nightingale where she uses the terms 'profession' and 'my calling' synonymously. The publication of the Briggs Report in 1972 introduced the idea of a new professional status for nursing, proposed mainly through changes in how nurses were prepared for registration; education not training (see Chapter 1). Although it took seven years for some recommendations from the Briggs Report (1972) to be implemented (as part of the 1979 Nurses, Midwives and Health Visitors Act), the report and subsequent Act signalled a move away from the 'apprenticeship' and 'vocational' approach to nurse training and perhaps led to a change in the definition of 'profession' as applied to nursing. The Nursing and Midwifery Council's (NMC, 2015) '*The Code*' is subtitled as '*Professional standards of practice and behaviour for nurses and midwives*' and includes the statement, "This commitment to professional standards is fundamental to being part of a profession," (NMC, 2015, p.2). Does following a set of 'standards' and acting 'professionally' define an occupation as a 'profession', or do these standards just promote 'doing a job well'? Cribb and Gewirtz (2015) indicate that these are, at least historically, some of the 'traits' of a profession but there are also important social roles and expectations that should be considered. Fenwick and Nerland (2014, p.2) acknowledge that the term 'professional' is both problematic and highly debated, but do conclude that a professional is,

> [A member] of any occupational group, usually committed to public service, that defines itself as collectively sharing particular knowledge and practices, and that is publicly accountable for its service.

Although there is ongoing debate regarding the strength and uniqueness of the 'particular knowledge' of nursing, this definition would suggest that nursing is a profession and supports the stance taken in this study. The RCN (2014, p.10) suggest,

> Professional practitioners (the doctor, the nurse, the lawyer) use their knowledge to identify and understand the problems presented by the client and to identify ways of solving them. The professional's knowledge base includes some knowledge that is shared with other people, but also includes discipline-specific knowledge about the particular conditions or problems which constitute the discipline's 'phenomena of concern' and the particular interventions that can be used to overcome them. This is the profession's particular domain – their particular expertise, or what they know about.

This statement too supports the view that nursing is a profession and outlines, at least in part, some discussion on the relevant 'knowledge base'.

Figure 3.1 outlines the conceptual framework for this study. It acknowledges key influences on the undergraduate student nurse and a number of 'expected outcomes'. These influences and expected outcomes will be explored in more detail.

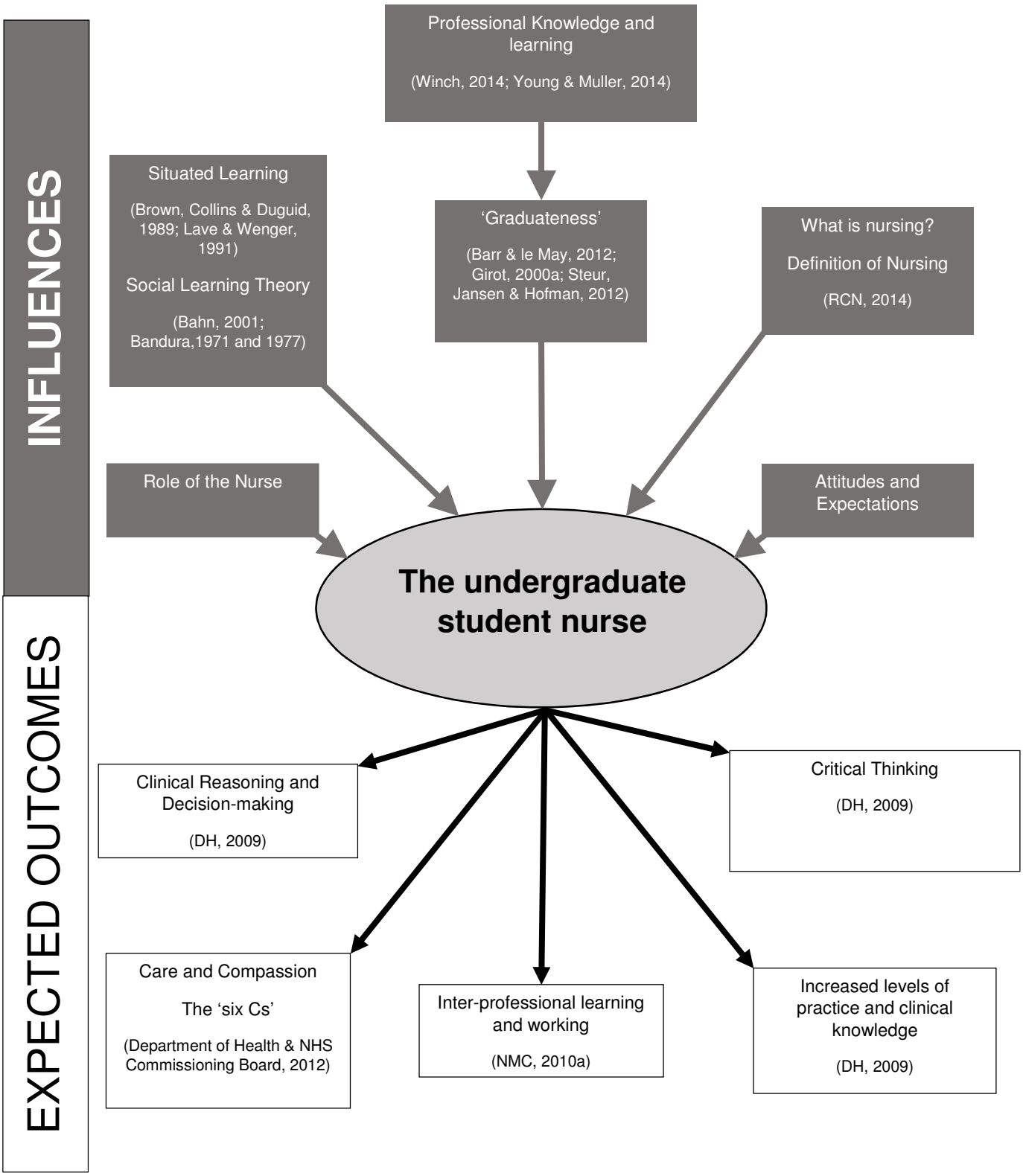

Figure 3.1: Conceptual framework – All graduate entry to nursing

3.2 Influences

3.2.1 What is nursing? A definition

Defining what nursing is, what nurses do, and therefore what knowledge base is required has been the subject of much debate and conjecture throughout the history of nursing and nurse education (Burke & Harris, 2000; Cook & Webb, 2002; Davies, 1977; White, 1976). Nonetheless, the RCN's Nursing Policy and Practice Committee (RCN, 2014) reviewed the definition of nursing devised by the organisation in 2003, confirming its validity and currency. The definition was developed by nurse leaders following consultation with and participation from a wide range of RCN members, a review of published international literature, a survey amongst members of the International Council of Nurses (ICN), and a review of definitions used in other countries around the world. Therefore, the definition is relevant for nurses and nursing in the UK, but also offers a definite international focus as well. It is the definition of nursing that underpins this study. It states that nursing is,

> The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.
>
> (RCN, 2014, p.3)

In support of this definition, the RCN (2014) outline six defining characteristics.

1. A particular purpose: to promote health, healing, growth and development, and to prevent disease, illness, injury, and disability.
2. A particular mode of intervention: concerned with empowering people, and helping them to achieve, maintain or recover independence.
3. A particular domain: people's unique responses to and experience of health, illness, frailty, disability and health-related life events in whatever environment or circumstances they find themselves.
4. A particular focus: the whole person and the human response rather than a particular aspect of the person or a particular pathological condition.
5. A particular value base: ethical values which respect the dignity, autonomy and uniqueness of human beings, the privileged nurse-patient relationship, and the acceptance of personal accountability for decisions and actions.

6. A commitment to partnership: with patients, their relatives and other carers, and in collaboration with others as members of a multi-disciplinary team.

(RCN, 2014, p.3)

The RCN does acknowledge that other healthcare professionals share some of these characteristics but states it is the unique combination and totality of them that defines nursing.

3.2.2 The role of the nurse

Identifying what it is that nurses actually do, the uniqueness of the role, is inextricably linked to the definition of nursing. From an education provider perspective it is a vitally important issue. Nursing is a 'broad church' and thus the role will look very different across the fields of nursing and across the numerous different clinical settings, but is there a set of attributes that appear common across these settings and would assist in identifying what the role of the nurse actually is?

The broad scope of different clinical settings, emerging 'specialists', and particular situations/circumstances has led to a myriad of papers that focus on a particular aspect, setting, or patient/service user group. Whilst these papers have merit, their distinct focus does not help clarify what the more 'generic' role of the nurse is. In a robust concept analysis, Mendes, da Cruz and Angelo (2015) provide a detailed account of the antecedent, defining attributes and consequences of the nurse's clinical role (summarized in Table 3.1). They recognise that the clinical role of the nurse is complex and multifaceted, and identify that much of the literature fails to give any explicit idea of what this role is. They argue that the clinical role of the nurse, "takes place in a space of interaction between the nurse and client, whether these are individuals, families, groups or communities," (Mendes *et al.*, 2015, p.321). Following their analysis, they provide the following statement,

> The constituent element of the clinical role of the nurse is the interaction between the nurse and a person, family or group, in view of the decision processes that conduct care experiences and the governance of the environment of interaction. It is characterized by evidence-based, patient-centered care, continuously seeking to improve care outcomes, and requires professional commitment,

> ethical awareness and zeal for accuracy and reliability. It is based on an effective interaction process with the health team, as well as on commitment to nursing preparation and lifelong learning. From nurses, it demands critical thinking and informed experience applied to the phenomena that patients experience, associated with clinical autonomy, professional accountability, role valuation and care foundations. As consequences, the clinical role influences identity, development and professional socialization, improvement in quality of care and enhancement of the structure and dynamics of health work.
>
> (Mendes *et al.*, 2015, p.327)

Table 3.1: Summary of antecedents, defining attributes and consequences of the clinical role of the nurse (adapted from Mendes *et al.*, 2015, p.326)

Antecedents	Defining attributes	Consequences
Critical thinking. Informed experience. Clinical autonomy, professional accountability, valuation of work role and fundamentals of care to patients.	Interaction with the client. Interaction goals. Care experiences: Evaluation/assessment. Diagnosis. Planning. Intervention. Care space governance. Patient-centred care. Strategies and practices for improving the care outcome. Evidence-based practice. Professional commitment, ethical awareness and zeal for accuracy and reliability. Effective, collaborative, facilitative and equalitarian interaction with the health team. Commitment to the permanent nursing formation and education.	Impact on the identity, development and professional socialisation. Improved quality of care. Enhancement of the structure and dynamics of health care.

Mendes *et al.* (2015) suggest that their study provides a clear articulation of the role and responsibilities of the nurse, which should be useful for academics in nursing who have a responsibility to nursing students in preparing them for this role. As the authors identify, many of the papers analysed in their study were British, therefore addressed the role of the nurse in a UK context. As such this paper provides a useful overview of the role of the nurse for the purposes of this conceptual framework and study.

3.2.3 Professional knowledge and learning

If it is difficult to define a 'profession' then defining 'professional knowledge' is likely to be problematic too. The struggle for a definition is not helped by the number of theories or models of knowledge that present different perspectives on its characteristics and development (Eraut, 1994; Young & Muller, 2014). However, having a distinct 'knowledge base' is an important distinguishing feature of a profession. Nursing has been accused of not having a distinct knowledge base (McNamara & Fealy, 2014) or one that is, "not useful," (Meerabeau, 2005, p.125). In a critique of nursing knowledge in relation to the concept of 'caring', Paley (2001, p.195) suggests,

> Nursing conceives of knowledge as a list of attributes, generated by association and resemblance - attributes which are continually aggregated, in such a way that the findings of one study, whether empirical or theoretical, always overlap substantially with the findings of previous ones. Moreover, as these attributes are distilled, exclusively, from 'things said', the probability that this tedious parade will ever be halted by an encounter with reality is zero.

Young and Muller (2014) suggest that there are two kinds of knowledge, 'knowledge that' (KT) and 'knowledge how' (KH), both of which must be considered in discussions on professional knowledge. Winch (2013 and 2014) discusses a third variation, 'knowledge by acquaintance' (KA) which is primarily acquired via the senses and may be facilitated through becoming acquainted with objects, events, processes, states and people. This has clear resonance with nursing and the knowledge obtained 'in-context' by becoming acquainted with patients/service users, RNs, health care assistants (HCAs), other health professional staff and fellow students. The students will also become acquainted with the sights, sounds and smells of different clinical practices and situations, all of which assist in the development of clinical reasoning (Levett-Jones *et al.*, 2010).

To some extent, KT is theoretical knowledge and KH is practical knowledge. As Young and Muller (2014, p.13) state, "Professional knowledge is both 'theoretical' … and 'practical'." Winch (2013, p.131) provides further links between the two suggesting,

> Knowing how (KH) to do something is an epistemic capacity at the very least related to knowledge by acquaintance and KT if for no other reason that knowing how to do something usually requires some elements of the other two kinds of knowledge. KH involves recognising and following rules for carrying out actions and the exercise of intentional agency. It is, therefore, a more specialised form of ability than those that are part of our instinctive structure such as the ability to breathe or digest.

Both Young and Muller (2014) and Winch (2014) outline the fact that professional knowledge not only involves the purely 'theoretical' KT, but a knowledge of 'how' to bring different theoretical propositions together relevant to the particular subject or context. An example from clinical practice may help explain this; the 'task' of assisting a patient/service user to move up the bed. This should involve an understanding of the anatomy and physiology of the skin, of physics and ergonomics, of personal health and safety, of how these 'theoretical concepts' fit together, as well as knowledge of how to use relevant moving and handling aids and techniques without causing injury to either themselves or the patient/service user. That is just for the 'moving' aspect of this therapeutic engagement. Simultaneously, the nurse will also be gathering fundamental information regarding for example, the patient/service user's conscious level, levels of pain and discomfort, skin integrity, temperature and colour, and psychological well-being. I would argue that not only should a professional curriculum include KT, KH and KA but also offer clear integration of these different 'theoretical' perspectives of knowledge. As can be seen by the clinical example given above, the nurse must be able to instinctively integrate KT, KH and KA seamlessly in order to complete what could be defined as a relatively simple procedure.

No discussion on knowledge in nursing would be complete without some reference to Barbara Carper's seminal work on 'knowing in nursing', published in 1978. Carper (1978) identified four patterns of knowing:

1. Empirics; the science of nursing
2. Aesthetics; the art of nursing
3. Personal knowledge
4. Ethics; moral knowledge in nursing

Empirics: the science of nursing

Carper (1978) acknowledged at the time that there was a desperate rush to develop empirical knowledge specific to nursing. She identified a change from a generally descriptive approach to a more theoretical, analytical one in the nursing literature and concluded, "the first fundamental pattern of knowing in nursing is empirical, factual, descriptive and ultimately aimed at developing abstract and theoretical explanations. It is exemplary, discursively formulated and publicly verifiable," (p.15). This clearly resonates with Young and Muller's (2014) 'knowing that' (KT).

Aesthetics: the art of nursing

Carper (1978) suggests that nursing literature at the time focused more on the empirical and factual knowledge, and paid little credence to the 'art' of nursing. Carper (1978) defines the 'art' as manual and technical skills involved in nursing practice – what Young and Muller (2014) would define as knowing how (KH). The use of the term 'aesthetics' suggests a notion of how something looks, an appreciation of its beauty (or otherwise), which would indicate that the art of nursing is somewhat more than physical or technical ability. Carper's (1978) use of the term 'art' coincided with an increased use of it in nursing literature and led to the publication of a number of papers in the late 1990's debating the term and its meaning. In one paper, Edwards (1998) suggests that there was little consideration in the nursing literature given to a definition of the term 'art', and based on Collingwood's '*The Principles of Art*' published in 1958 (cited in Edwards, 1998) Edwards offers a robust critique of the terms 'aesthetics' and 'art' as applied to nursing, concluding that nursing is not an art but a craft. In defining nursing as a craft, he is dismissive of the term 'aesthetics' stating, "It is surely the case that good nurses need not have a beautiful appearance, nor need they act beautifully," (p.393), suggesting further that neither the 'performance' or 'end-product' of a craft needed to exhibit aesthetic properties. Jenner (1997) suggests, "beauty and pleasure often are associated with art but are not essential attributes," (p.9), indicating that the art of nursing is the, "creative use of oneself, based upon knowledge and expertise, to transmit emotion and meaning to another," (pp.8-9). Wainwright (1999) adds somewhat to the conceptual confusion by suggesting that nursing is not a fine art or a performing art, but is an art in a more general sense, related to a craft or skill. He further concludes that if nursing is an art, it is the whole

of nursing that is defined as such, not just one aspect of it, and therefore the term ‘art’ can be deleted and the concept referred to simply as ‘nursing’. So where does that leave the discussions when attempting to define the art of nursing and its links with ‘knowing’ in nursing? The conceptual framework used for the current study would accept that nursing is not a ‘fine art’ considered alongside painting, sculpture, poetry, music and architecture (Wainwright, 1999), nor is it a ‘performing art’ considered alongside drama and dance, as Parse (cited in Wainwright, 1999) would suggest it is. There is an element of ‘application’ and an ‘in-context’ element to the ‘art of nursing’ and as such it will be evident in many different ways. A quote from Deborah Finfgeld-Connett (2008) from her concept synthesis of the art of nursing helps illustrate this. She concludes,

> The art of nursing appears to consist of expert use and adaptation of empirical and metaphysical knowledge and values. It is relationship-centered and involves sensitively adapting care to meet the needs of individual patients. In the face of uncertainty, creativity is employed in a discretionary manner. Artful nursing promotes beneficent practice and results in enhanced mental and physical well-being among patients. It also appears to result in professional satisfaction and personal growth among nurses.
>
> (Finfgeld-Connett, 2008, p.383)

It is also worth considering the content of a blog published on the Huffington Post from an Emergency Nurse, Ali Lomas. Ali was a model and award-winning photographer, who following a commission to photograph Dame Christine Beasley (former Chief Nursing Office at the Department of Health) was inspired to become a nurse. In her blog Ali concludes,

> There, in the emergency room, my mind, my compassion, my empathy and my knowledge become my most important assets. Everything I can offer comes from within. Until I started this I didn't know the difference you could make to someone's day, to their life by just your presence, a smile, a hug or a cup of tea, even when there are no words. It has brought perspective to my life and I love being a nurse.
>
> (Lomas, 2016)

Whilst this is not taken from a peer-reviewed academic source, and it is the thoughts of just one RN, Ali's account here does sum up much of what has been discussed in this section as the 'art of nursing'. Indeed, her blog allows limited comparison between the 'art of nursing' and the 'art of photography'. For their study investigating students' perspectives on the art of nursing, Duran and Çetinkaya-Uslusoy (2015) interviewed 54 Turkish nursing students and suggested that the art of nursing included three themes: interaction (between nurse and patient/service user), professional values, and use of professional knowledge. Although by the authors' own admission this was a small-scale study limited to one university in Turkey, and they appeared to get a little confused towards the end of their paper between the art of nursing and the use of art in nurse education, nonetheless, these three themes are apparent in Lomas' (2016) statement.

Personal knowledge

According to Carper (1978), personal knowledge in nursing is at the heart of the therapeutic relationship between the nurse and the patient/service user. It incorporates the 'therapeutic use of self' by both the patient/service user and the nurse. Carper (1978, p.19) writes,

> The nurse in the therapeutic use of self rejects approaching the patient-client as an object and strives instead to actualize an authentic personal relationship between the two persons.

As Carper (1978) discusses, this approach may lead to tensions when the patient/service user as 'self' has a different perspective on health and wellbeing to the nurse as 'self', but emphasises the right to individual choice, dignity and respect whatever their beliefs.

Ethics: moral knowledge in nursing

According to Carper (1978) the moral component of the patterns of knowing focuses on what ought to be done. Carper (1978) argues that it is not sufficient to 'know' the codes or principles that govern ethical practice (which are often unhelpful in dealing with the realities of moral dilemmas that can occur in clinical practice), but the RN must consider the moral choices in relation to the given situation and actions to be taken.

Carper (1978) acknowledges that an understanding of these patterns of knowing will not extend the range of nursing knowledge but will allow some critical focus on what it means to know and what types of knowledge nursing holds (or held) most valuable. What is apparent is that three of the four patterns of knowing include elements of KT, KH and KA. The exception would be 'science of nursing' where the focus on the empirical, abstract and verifiable suggests an orientation towards KT.

Knowledge of and in nursing is complex and multifaceted. Observers of nursing history may argue that, especially under the apprenticeship approach to 'training', nursing was accused of lacking any real theoretical knowledge base. My own experiences as an 'apprentice' student nurse (1984-1987) suggested far more focus on KH (I learnt how to do tasks safely and efficiently) and KA (I was taught by RNs and experienced the realities of clinical practice caring for real people) but rarely considered, understood or challenged the underpinning theoretical knowledge behind 'why we did what we did'. Experiences like mine are reflected in the comments about the apprenticeship model in the Willis Commission report (RCN, 2012). Nursing has increasingly embraced the importance of KT and is developing its own theoretical knowledge base. An undergraduate programme would suggest an increase in KT, but a balance between KT, KH and KA must be achieved, not forgetting the individual patient/service user–nurse relationship that is at the heart of what nursing is. The student nurse does need to have more of a theoretical knowledge base than some would acknowledge. The accusation of being 'too clever to care' would seem to undermine the importance of this theoretical knowledge in order to deliver safe, effective, competent and considered nursing care (Scott, 2004).

3.2.4 'Graduateness'

According to Steur *et al.* (2012) the search for the meaning of graduateness is as old as university education. Clinton *et al.* (2005), suggest graduateness could be viewed, from a nursing perspective, as the distinction between nurses qualifying following degree programmes and those from diploma programmes. This hardly explains what the distinctive differences are. What is 'graduateness'? What, if any, are the skills and attributes that distinguish a graduate from a non-graduate?

Graduateness has several possible attributes depending on the particular perspective (Steur *et al.*, 2012), with Stacey, Pollock and Crawford (2015) suggesting that these are often based on personal opinion or speculation. However, there appears to be some consensus on what many of these attributes are. They include analytical reasoning (Baldwin, 2004), critical thinking (Barr & le May, 2012; Clinton *et al.*, 2005; Girot, 2000b) demonstrating an understanding of research (Barr & le May, 2012; Clinton *et al.*, 2005), and the ability to know how to decide which research findings to implement in a particular situation (Barr & le May, 2012). Other skills and attributes of graduates include critical evaluation, strategic thinking, the ability to draw on theory, challenge practice and work creatively (Clinton *et al.*, 2005), innovative leadership, flexibility, having the ability to manage resources and handle change (ENB, 1999), and a commitment to lifelong learning (Johnsson & Hager, 2008; Steur *et al.*, 2012). There is the suggestion that these attributes should be included in any undergraduate programme (Clinton *et al.*, 2005) and should be 'measurable' (and therefore open to 'testing') at the end of the programme (Holmes, 2013). However, Steur *et al.* (2012) suggest that graduateness is one stage on the intellectual development of an individual learner, rather than any absolute measure at the end of a programme of study.

van Teijlingen (2015) provides a view of 'profession' based on trait theory where he identifies the key attributes of a profession. Using the same principles, the list of skills and attributes of graduateness presented above could be seen as 'traits'. Holmes (2013) introduces a 'realist approach' which he describes as being an extension of this skills and attributes approach. He contrasts this with a 'relational approach' which,

> Conceptualises graduate identity very differently, in terms of interactionist, constructionist social theory. The social order, including the positions, roles, identities available to persons, is viewed as a negotiated outcome of constant interaction, within which any stabilised or structured arrangements are always and essentially temporary, subject to possible contestation and change.
>
> (Holmes, 2013, p.1045)

This approach compares with Cribb and Gewirtz's (2015) view of the 'inside' and 'outside' perspectives of professional identity. In other words, the 'inside' view would

recognise the skills and attributes that an individual graduate should portray, and the 'outside' view would examine how these skills and attributes are recognised, negotiated and given meaning in the relevant social context (or profession), and in society more generally. What needs to be considered too is any effect that society's view on whether a given profession should be afforded 'graduate status' might have.

The concept of being more employable is also discussed as an aspect of graduateness (Holmes, 2013; Johnsson & Hager, 2008). Tomlinson (2008, p.51) discusses a traditional social control element for earning a degree suggesting that graduateness served as confirmation of status for the middle (and those aspiring to be) classes, granting them an occupational advantage. This 'traditional perspective' must be considered in light of the 'widening participation' agenda (Department for Employment and Learning, 2010). Although it is beyond the scope of the current study to offer any critique of the merits or success of this initiative, the university where the study was based does participate in widening participation therefore this may have impacted on the demographics of the students in the 2012 cohort.

Within the concept of graduateness and an attempt to identify what it means, it is significant to compare a section of the document *'Standards for pre-registration nursing education'* published by the NMC in 2010 with the '*Standards of proficiency for pre-registration nursing education'* document (NMC, 2004) that it replaced. The 2010 edition includes the statement,

> Nurses must be equipped to lead, delegate, supervise and challenge other nurses and healthcare professionals. They must be able to develop practice, and promote and sustain change. *As graduates* they must be able to think analytically, use problem-solving approaches and evidence in decision-making, keep up with technical advances and meet future expectations.
>
> (NMC, 2010c, p.4, emphasis added)

The 2004 edition that preceded it states, "The level of learning must be such as to facilitate the achievement of knowledge, understanding and skill acquisition, and the development of critical thinking, problem-solving and reflective capacities essential to complex professional practice," (NMC, 2004, p.17). Recognising the need for and

initiating change are addressed within the 2004 standards, but whilst noting that some of the 'traits' are similar, it is important to consider the reference to the 'graduates' and the attributes associated with being graduates. It is also significant to note how these attributes are associated with a more overt reference to 'sustaining change' and 'challenging other nurses and healthcare professionals' when compared with the 2004 document. The inclusion of the term 'skill acquisition' in the 2004 extract is also worthy of further comment. Nursing is a practice-based discipline. The acquisition of 'essential skills' and demonstration of competence of these skills are key components of any pre-registration programme. These essential skills are included in the 2010 document. Their omission from the quotes above around 'level of learning' (NMC, 2004) may indicate a possible move away from 'practitioners who can think' to 'thinkers who can practice'.

In their study on the perceptions of education purchasers (n=34) from across England on nursing as an all graduate profession, Burke and Harris (2000) identified that most of the participants could articulate the qualities of being a graduate, including the ability to challenge poor practice. They even recognised the benefits that graduate nurses could bring to clinical practice in terms of leadership, assertiveness and critical reflection, but most agreed that it was not necessary for all, or even most, of the nursing workforce to have such skills. Some felt that the graduate nurses would not want to carry out 'basic nursing care duties'. Although this study is several years old and there have been changes in how healthcare education is 'purchased', the tension between the need to educate the nursing workforce and the need to have nurses working clinically still exists (Morrall & Goodman, 2013).

3.2.5 Situated Learning Theory

Situated learning (or cognition) is a learning theory that endorses the concept of learning as a social process which is dependent on the situation/culture in which it occurs (Brown, Collins & Duguid, 1989; Lave & Wenger, 1991; Onda, 2011). Learning embedded in 'authentic activities' will promote transformation of the theoretical and abstract to the practical and 'in-context' (Brown *et al.*, 1989; Onda, 2011). Brown *et al.* (1989) use the analogy of a tool to describe this concept a little further suggesting that any tool can only be fully understood through use. A tool may be 'familiar', but

unusable to an individual. The authors highlight that abstract knowledge (compare with KT) may introduce the tool, describe its properties, provide useful examples of it and let the students 'touch and feel it' (KA), but it is only through use in authentic situations that the student will understand it and really learn how to use it (KH). Indeed, the tool may have a particular purpose in a particular community or culture, therefore further understanding of the tool, its scope and applicability is closely linked with the culture in which it is being used. Situated learning also recognises the crucial role of the 'expert' and how the novice learns initially by observing the expert, followed by increased involvement and acceptance as part of the community/culture (Brown *et al.*, 1989; Cope, Cuthbertson & Stoddart, 2000; Lave & Wenger, 1991). Lave and Wenger (1991) introduce the term 'legitimate peripheral participation' (LPP) highlighting the fact that initially at least, the 'novice' will not have the required skills and knowledge to play a central role in the community, but will be allowed to participate in more peripheral aspects. However peripheral the activity may initially be, it is nonetheless authentic and, as Lave and Wenger (1991) emphasise, involvement in it is a key element of socialisation. For learning to take place the novice must become part of the community. Lave and Wenger (1991, p.53) state,

> As an aspect of social practice, learning involves the whole person; it implies not only a relation to specific activities, but a relation to social communities - it implies becoming a full participant, a member, a kind of person. In this view, learning, only partly - and often incidentally - implies becoming able to be involved in new activities, to perform new tasks and functions, to master new understandings. Activities, tasks functions and understandings do not exist in isolation; they are part of broader systems of relations in which they have meaning.

LPP not only suggests that learning is required as a condition *for* membership of a community/culture, and therefore it could be argued, can be undertaken separate or away from it, but is itself an evolving form *of* membership (Lave & Wenger, 1991). This has implications not only for the student, but also for the existing members of the community – the 'old-timers' as Lave and Wenger (1991) refer to some as. The introduction, development and enculturation of the student will have an impact on the community. LPP is required for the continuity of the community and the ultimate

replacement of ‘old-timers’ by ‘newcomers’ who will in turn become ‘old-timers’. As Lave and Wenger (1991, p.115) suggest,

> The different ways in which old-timers and newcomers establish and maintain identities conflict and generate competing viewpoints on the practice and its development. Newcomers are caught in a dilemma. On the one hand, they need to engage in existing practice, which has developed over time: to understand it, to participate in it, and to become full members of the community in which it exists. On the other hand, they have a stake in its development as they begin to establish their own identity in its future.

LPP also involves relations of power. Lave and Wenger (1991) suggest that the move from peripheral participation to more intensive participation is empowering. Any block on participating more fully is disempowering. The student nurse as they progress through the programme, should be permitted more intensive participation. It is important that mentors in clinical practice are aware of the stage of training and are afforded the opportunity to discuss with individual students the different experiences that they (the students) have had in order to best gauge the level of participation and continue to promote learning and socialisation. If LPP promotes learning then isolation or exclusion from legitimate participation will impede it.

Situated learning clearly resonates with pre-registration nursing education. The aspects of learning ‘in-context’ from an ‘expert’, of developing an identity, becoming socialised and accepted as a member of the community, not just at point of registration, but crucially during the learning process as well, and the role that student nurses and newly qualified RNs can play in influencing the setting (‘community’) in which they work are all significant. Through LPP, the student nurse does not just learn *from* talk but learns *to* talk as a member of the community of practice (Lave & Wenger, 1991). They begin to behave as practitioners, not students, developing their conceptual understanding through social interaction and collaboration. However, it is important to recognise that the student nurse will be exposed to several ‘cultures/communities’. The university, the four fields of nursing, the different placements working with different 'old-timers' are key examples of these different communities. What would be considered accepted practice in one setting would be

viewed unacceptable in another. This underlines the necessity for the nursing student to have the skills, knowledge, competence and confidence to question practice and to identify what best practice actually is.

Lave and Wenger (1991) also suggest that the element of identity and membership afforded by LPP is strongly linked with motivation. Bandura's (1971 and 1977) Social Learning Theory[2] also addresses the concept of motivation recognising that in some circumstances, e.g. thirst or pain, the motivation to seek, in these cases, fluid or analgesia is immediate. However, the theory also recognises that in many circumstances, motivation may need to be sustained over a long period of time when 'rewards' may not be immediately apparent. Bandura (1977) argues that cognitive representations of future outcomes act as major motivators. The theory supports the concept of learning as a social activity, but the element of self-motivation plays a crucial role. The individual learner needs to set goals for themselves, either striving for positive outcomes, or avoiding negative ones. Bandura (1989) also suggests that the learner must sustain a level of self-belief in their abilities in order to sustain motivation and perseverance over a longer period of time; the greater the self-belief, the greater and more sustained the efforts to achieve. Bandura (2001) discusses the aspect of being an 'agent'; intentionally making things happen by one's own actions.

Although the inference may appear to be that 'authentic' activity and therefore situated learning for the nursing student can only take place in actual clinical settings, this is far from the truth. Authentic activities and communities of practice can be established in the academic setting through, for example, the use of simulation (Bland, Topping & Tobbell, 2014; Paige & Daley, 2009; Woolley & Jarvis, 2007). Simulation allows for the development of 'authentic' environments and scenarios, promotes active student engagement (Bland, Topping & Wood, 2011), and has a clear social element to it; the establishment of 'communities of practice', as the students often work in small groups. Theory is integrated to practice 'in-context', often promoting the 'a-ha' moment that suggests understanding (Hope, Garside & Prescott, 2011). Significantly, Bland *et al.* (2014) argue, simulation places the *student's* needs at the centre, whereas the clinical environment will place the *patient/service user's* needs at the centre, possibly impacting on the learning opportunities for the student.

Lave and Wenger's (1991) use of the term 'old-timer' is worth further exploration. They hint that the old-timer is a person based in the authentic setting – the expert from whom the novice will learn from. However, this needs to be viewed from the perspective of the academic setting too. Most of the academic staff who teach on the pre-registration nursing programme where the current study was based are RNs with many years of clinical experience between them. Some continue to work in clinical practice on a regular basis. They are 'old-timers' and their influence on the development and socialisation of the student nurse must not be overlooked. Both Brown *et al.* (1989) and Lave and Wenger (1991) highlight the importance of conversations, narratives and 'war stories' for the development of members of a community. Academic staff have authentic and meaningful war stories to tell. As old-timers, they will not only be able to offer a theoretical perspective (KT), but will understand the 'in-context' and in doing so will be able to integrate aspects of the KH and KA. This integration will stand on its own as part of the students' development, but will also contribute towards their preparation for clinical placement where the 'in-context' should be realised in a more meaningful way.

Finally, Lave and Wenger (1991, p.103) suggest,

> Control and selection, as well as the need for access, are inherent in communities of practice. Thus access is liable to manipulation, giving legitimate peripherality an ambivalent status. Depending on the organisation of access, legitimate peripherality can either promote or prevent legitimate participation.

Historically in nursing, the communities of practice (for example individual hospitals, Health Authorities or Trusts) controlled the selection and access of newcomers to the community. Student nurses were employees of the individual organisations and were more readily identified as 'belonging'. (I still view myself partly in relation to the hospital where I trained – i.e. I am a 'Dewsbury nurse' which brings with it a certain legitimacy and membership of a community of practice). The move of nursing education from the hospital based Schools of Nursing to Higher Education Institutions (HEIs) altered this selection of students and access to the authentic clinical settings. Students are now recruited by HEIs and access to the clinical setting is negotiated on

their behalf. They are identified primarily as students of a university, not as trainee members of staff of the healthcare organisation.

Both Brown *et al.* (1989) and Lave and Wenger (1991) use the term 'apprenticeship' to identify, in part, the relationship between the student/novice/newcomer and the mentor/expert/old-timer. In the context of nurse education today, care needs to be taken not to assume that the relationship is identical to that considered the norm in the 'apprentice-style training' of nurses that continued up to the move to HEIs in the mid to late 1990s. The learning experience today must be more than the imitative style, where the acquisition of knowledge was in essence via an accumulation of un-rationalised experiences.

3.2.6 Attitudes and experiences

Immediately following the announcement of the move to an all graduate entry to nursing in England, the nursing and general press published various articles and opinions about the move. Many were negative, mirroring what happened in Ireland as presented by McNamara (2008). Shields, Watson and Thompson (2011) provide a useful summary of much of this published material, including a review of the Political views following the 2010 General Election. As has been discussed elsewhere, this study focused on the attitudes of nurse and AHP educators to the move, as well as investigating the experiences of nursing students and nurse educators during the running of the first all graduate programme at one university. One of the reasons for including this aspect of data collection, and the place of 'attitudes and experiences' in the conceptual framework, was to be aware of how, if at all, the range of attitudes may affect the experiences of educators and students. In many respects, the voice of the current nursing student has been noticeably absent from the debates surrounding the move to an all graduate entry. In addition, as Cho, Jung and Jang (2010, p.180) suggest, "Although career choice has been studied over several decades, further research must examine changes and differences in generational cohorts who might possess different personal values, career perceptions and expectations, and have been raised in different social environments." Although the authors were alluding here to different geographical social environments, writing as they were from a South

Korean perspective, the move to an all graduate entry did create a 'different social environment' within nursing in England.

3.3 Expected outcomes

3.3.1 Critical thinking

Gloudemans, Schalk and Reynaert (2013, p.276) state,

> Nurses with a Bachelor's degree are believed to use higher levels of cognitive skills: in higher education nursing programmes students for example learn how to analyse situations, reflect on their performance, evaluate interventions and make clinical judgements. In other words, they learn how to develop meta-cognitive skills known as critical thinking skills. This helps them cope with difficult, more complex and unexpected situations. They show initiative in learning how to deal with these kinds of situations, and thereby increase their level of self-efficacy.

One of the key outcomes of graduate education is the development of critical thinking skills (Girot, 2000a; Kreber, 2014). The concept of critical thinking dates back to the Greek philosophers and indicates a capacity to inquire, explore and synthesise ideas (Burrell, 2014; Fero, Witsberger, Wesmiller, Zullo & Hoffman, 2009). Since the 1980's critical thinking has been increasingly debated in relation to nursing and nurse education (Burrell, 2014; Profetto-McGrath, 2005; Raterink, 2008). Many authors agree that there is a lack of a universally acceptable definition for critical thinking. It is a complex phenomenon that involves analysis (Burrell, 2014; Chan, 2013a; Facione & Facione, 2007), described as 'robust' by Morrall and Goodman (2013) and 'rational' by Zuriguel Pérez *et al.* (2015), the gathering, seeking and interpretation of information (Chan, 2013a), thoughtful problem-solving (Facione & Facione, 2007), and the application of theory (Chan, 2013a). Facione, Facione and Sanchez (1994) describe critical thinking as 'giving reasoned consideration', and Profetto-McGrath (2005) suggests it is likely to require the suspension of judgements. In addition, critical thinking involves 'self-regulation' or 'meta-cognition'; the ability to think critically about oneself (Facione *et al.*, 1994; Facione & Facione, 2007; Gloudemans *et al.*, 2013; Kim, Moon, Kim, Kim & Lee, 2014). There is an element of discipline-specific criteria to any definition of critical thinking (Pitt, Powis, Levett-Jones & Hunter, 2015; Zuriguel Pérez,

et al., 2015) with Raterink (2008) suggesting that critical thinking in nursing must also include creativity and intuition.

There is some, though inconsistent, evidence that critical thinking improves patient/service user outcomes (Burrell, 2014; Chan, 2013a; Fero *et al.*, 2009; Fesler-Birch, 2005) and is therefore vital in nursing (Chan, 2013b; Lechasseur, Lazure & Guilbert, 2011). Critical thinking is a learned skill, not automatic (Martin, 2002), and should be included in any undergraduate and post-graduate nursing programme (Chan, 2013a; del Bueno, 2005). Just like competence (Benner, 1984), there is a 'development' of critical thinking from the novice to the expert, with experienced nurses demonstrating critical thinking and its links with clinical reasoning more clearly than students and more junior/novice nurses (Fero *et al.*, 2009). Linked with this, there is some evidence to suggest that graduate-level nurses demonstrate more critical thinking than their non-graduate colleagues (Fero *et al.*, 2009; Gloudemans *et al.*, 2013) although this is not consistent (Martin, 2002). There is also evidence to show that levels of entry critical thinking determine academic performance and course completion (Pitt *et al.*, 2015). According to Zurmehly (2008) critical thinking leads to better job satisfaction for RNs. There is mixed evidence of the effectiveness of educational programmes in developing critical thinking skills (Pitt *et al.*, 2015), perhaps, it is argued, due to the way nursing is taught (del Bueno, 2005; Fesler-Birch, 2005) with an emphasis on developing the skilled practitioner (Morrall & Goodman, 2013), a carryover from the 'knowledgeable doer' of Project 2000 (UKCC, 1986), and the different influences that have led to what Shields, Morrall, Goodman, Purcell and Watson (2012) describe as the 'dumbing down' and de-intellectualization of academia in general and nursing more specifically.

In her study amongst RNs working in long-term care facilities in the USA, Raterink (2008) asked her focus group participants to discuss characteristics that enhanced their ability to use critical thinking. These were teamwork, and staffing arrangements that allowed some consistency with who they worked alongside and the patients they cared for. Three of the eleven participants indicated that the variety and acuity of patients allowed them opportunity to practice key skills. Barriers to utilizing critical thinking included too much paperwork, a feeling of being overworked leading to a lack

of sufficient time to complete the necessary 'tasks', and excessive criticism from colleagues, patients and their families (Raterink, 2008). Although this study focused on RNs, there are factors here that are significant for the student nurse working in clinical practice. The importance of working in a variety of clinical settings to enable the development of their critical thinking and clinical reasoning skills is clearly vital. Educators must work alongside colleagues in clinical practice to promote these 'enhancers' and limit the 'barriers'. This also highlights the need to consider the 'Ascent to Competence' framework developed by Levett-Jones and Lathlean (2009) during their study on student nurses sense of 'belongingness' in their clinical placements. The framework highlights the importance for the student to feel accepted, appreciated, recognised and respected for making a valuable contribution to patient care – becoming a member of the 'team', not an outsider. Perhaps of more significance to the academic setting is Chan's (2013a) reference to the work of Zygmont and Schaefer where they suggest that a barrier to the development of critical thinking was a lack of confidence. Students who lacked confidence did not express opinions or learn to think critically due to a fear of making mistakes. This can occur in the lecture room or simulation suite just as it can on the ward or in the patient's/service user's home. Chan (2013a) argues that educators undertake a pivotal role in teaching and assessing the application of nursing students' critical thinking.

3.3.2 Clinical reasoning and decision-making

Speaking at the Chief Nursing Officers' summit in 2009 where the move to an all graduate entry to nursing in England was announced, Ann Keen MP, Parliamentary Under-Secretary of State for Health at the time suggested that degree level education would provide new nurses with the decision-making skills they need to make high-level judgements (DH, 2009). In many of the papers discussed in the previous section on critical thinking, the link is made between critical thinking, clinical reasoning and decision-making in the clinical setting. According to Zuriguel Pérez *et al.* (2015), clinical reasoning is linked with the ability to make professional judgements, resolve problems and make diagnostic decisions. Fero *et al.* (2009) suggest that clinical decision-making focuses attention on the clinical nature of an issue but fails to demonstrate an understanding of the potential broader aspects of it. In their opinion, decision-making and critical thinking need to occur concurrently. A similar perspective

is offered by Profetto-McGrath (2005) who suggests that critical thinking is the foundation for clinical decision-making and allows students and RNs to think beyond established protocols and routines; as del Bueno (2005, p.281) states, "Knowing does not equal making clinical decisions." Girot (2000a) in her study of 82 nurses including year one undergraduates, year four undergraduates, mature graduates and experienced non-graduates, concluded that it was the combination of graduate status and experience that influenced and helped develop decision-making skills in practice rather than either factor alone. Girot (2000a) also highlighted that it was exposure to an academic process rather than experience that exerted a greater influence on decision-making.

Consideration of the descriptors for diploma (Level 5) and degree with honours (Level 6) published by the Quality Assurance Agency (QAA, 2014) highlight some relevant differences linked with the discussions on critical thinking and decision-making (Table 3.2). A review of these descriptors would suggest that the move to an all graduate entry to nursing is justified if higher levels of critical thinking, clinical reasoning and decision-making are required.

Table 3.2: Qualification descriptors (QAA, 2014)

Diploma (Level 5)	Degree with honours (Level 6)
1. Use their knowledge, understanding and skills to critically evaluate and formulate evidence-based arguments and identify solutions to clearly defined problems of a generally routine nature 2. Communicate the results of their study and other work accurately and reliably using a range of specialist techniques 3. Identify and address their own major learning needs within defined contexts and to undertake guided further learning in new areas 4. Apply their subject-related and transferable skills in contexts where the scope of the task and the criteria for decisions are generally well defined, but where some personal responsibility and initiative is required.	1. Apply the methods and techniques that they have learned to review, consolidate, extend and apply their knowledge and understanding, and to initiate and carry out projects 2. Critically evaluate arguments, assumptions, abstract concepts and data (that may be incomplete), to make judgements, and to frame appropriate questions to achieve a solution - or identify a range of solutions - to a problem 3. Communicate information, ideas, problems and solutions to both specialist and non-specialist audiences. **And holders will have:** The qualities and transferable skills necessary for employment requiring: a. The exercise of initiative and personal responsibility b. Decision-making in complex and unpredictable contexts c. The learning ability needed to undertake appropriate further training of a professional or equivalent nature.

3.3.3 Increased levels of practice and clinical knowledge

Peter Carter, Chief Executive and General Secretary of the RCN between 2007 and 2015 stated at the Chief Nursing Officers' summit in 2009 that,

> All nurses need to put quality care at the centre of what they do, *and* they also need extensive knowledge, analytical skills and experience to work in a range of settings … Many nursing roles are demanding and involve increasingly advanced levels of practice and clinical knowledge.
>
> (DH, 2009, emphasis added)

The NMC (2010c, p.4) state, "As autonomous practitioners, nurses will provide essential care to a very high standard and provide complex care using the best available evidence and technology where appropriate."

Writing from a North American perspective over thirty years ago, Benner (1984) stated that patient acuity, and the number of diagnostic and treatment interventions had increased. The intervening years since Benner's statement have seen a dramatic increase in each of these. Healthcare is becoming progressively more complex (Pitt *et al.*, 2015; Zuriguel Pérez *et al.*, 2015) as is the role of the nurse (Mendes *et al.*, 2015; Onda, 2012; RCN, 2012). As Ali and Watson (2011) discuss, nurses work in a wide variety of clinical settings, including the patient/service users own home, health centres and general practitioner (GP) surgeries, walk-in centres, care homes, hospices, and in 'non-healthcare settings' such as schools, colleges and universities, workplaces, police stations and prisons. The changes in patient acuity and technology are not limited to just the physically ill patient in a hospital setting. These changes need to be recognised across the four fields of nursing and across the wide range of clinical (and non-clinical) settings where nurses work.

3.3.4 Care and compassion

In the wake of several and much publicised examples of poor and negligent care across the public and private healthcare sectors in the UK, the Department of Health and NHS Commissioning Board (2012) published a document titled *'Compassion in Practice'*. Written by Jane Cummings, Chief Nursing Officer for England, and Viv Bennett, Director of Nursing, Department of Health and Lead Nurse, Public Health

England the document has since become known as the ‘six Cs’. In the foreword the authors write, “As health and social care changes what does not alter is the fundamental human need to be looked after with care, dignity, respect and compassion. To achieve this the enduring values of nursing and care must underpin our work,” (DH & NHS Commissioning Board, 2012, p.5). Healthcare has become more complex but the fundamental principles of care, compassion, dignity and respect must not be compromised. The ‘six Cs’ are care, compassion, competence, communication, courage and commitment. The authors of the document acknowledge that these values and behaviours are not new concepts, but that this vision provides an opportunity to reinforce these fundamental principles.

A great deal has been written in the nursing and general press regarding the move to an all graduate entry to nursing and how this would impact on nursing care (Castledine, 2009; McNamara, 2008). There are some accusations that graduate nurses will not want to undertake ‘basic nursing care duties’ even though there is no evidence to indicate that this is the case (Burke & Harris, 2000; Watson, 2006). Watson and Shields (2009, p.2925) suggested, “All the woes of the UK NHS are blamed on the fact that nurses are university educated or ‘too posh to wash.’” Castledine (2009) acknowledged that many hospitals were working under extreme pressures, but thought that to place the blame for this on the level of education of nurses did not consider the real issues affecting the NHS. To this end, Willis Commission (RCN, 2012, p.4) states,

> We found it totally illogical to claim that by increasing the intellectual requirements for nursing, … recruits will be less caring or compassionate. Such accusations are seldom made against other all-graduate professions such as medicine, midwifery or physiotherapy, and there is absolutely no evidence to support them in nursing.

The publication of the ‘six Cs’ was not met with universal approval, with many nurses publicly and privately indicating that the ‘real issues’ impacting on standards of care were workload and staffing levels.

3.4 Conclusion

This chapter has presented a conceptual framework for the current study. In doing so, it has highlighted some influences and outcomes that impact the undergraduate student nurse. What is clear is that both nursing and nurse education are complex, with numerous opinions and approaches. To do justice to and offer critique for all of these would be unfeasible. As a result, I have had to be selective in the literature used to underpin this conceptual framework and have attempted to provide some rationale for the choices made.

Footnotes

[1]It is worth noting that Cribb and Gewritz (2015) debate whether the terms 'professional' and 'professionalism' are socially acceptable in the twenty-first century. The debate centres on the notion of power and how this 'power' may be used – and historically was used – as a means of exercising social control. To illustrate this point they discuss the changes that have occurred in health and social care relating to patient and service user involvement in decisions concerning their care; in other words, what the Department of Health (DH) (2010 and 2012) would state was, "no decision about me without me," (DH, 2010, p.3). They compare this with the notion of 'compliance' where patients followed the doctor's orders. These changes in patient and service user involvement, and therefore the power relationships associated with healthcare, cannot and should not be ignored, but are not the main focus of the discussions here. By including a discussion of professionalism I am not suggesting in any way that nursing needs more 'authority', 'power' or 'social control' over patients and service users, but that other historical aspects, although now outdated, still appear to have significant influence on the way nursing is viewed *within* health and social care occupations should be considered. For example, Cribb and Gewritz (2015) point to the historical development of medicine as a male dominated, scientifically driven occupation with a focus on 'cure', compared to the female dominated occupation of nursing, with its emphasis on 'care'. Beck and Young (2005) refer to the, "unprecedented challenges," (p.183) that professions and professionals have faced over the last few years, highlighting areas such as autonomy, validity of 'calling' and claims of expertise based on specialised knowledge. At a time when nursing is once again debating its development and professional status, the traditional views, claims and expectations of professions and professionals in general are being called into question, and these challenges must be borne in mind.

[2] Bandura (1977, p.vii) states, "Social learning theory approaches the explanation of human behavior in terms of a continuous reciprocal interaction between cognitive, behavioral, and environmental determinants. Within the process of reciprocal determinism lies the opportunity for people to influence their destiny as well as the limits of self-direction. This conception of human functioning then neither casts people into the role of powerless objects controlled by environmental forces nor free agents who can become whatever they choose. Both people and their environments are reciprocal determinants of each other."

Chapter 4: Methodology: An inductive case study

4.1 Introduction

The aim of the study was to investigate student nurses' and healthcare educators' perceptions and experiences of all graduate entry to nursing in one University in England, with objectives to:

1. Critically investigate the attitudes and experiences of health educators in relation to an all graduate entry to nursing.
2. Critically examine the motivations of students for starting the programme and their expectations of the role of the qualified nurse from their field of nursing.
3. Critically evaluate the experiences of students undertaking the programme using a focus group based at the University.

The aim and objectives were informed by the outcomes of a small scale unpublished study that I undertook (Prescott, 2010). This smaller study concluded that educators in nursing at one United Kingdom (UK) university had mixed views in relation to the move to an all graduate entry to nursing. I felt that the study merited wider consideration, including the involvement of those who would be at the heart of this fundamental change to nurse education; the nursing students. No study based in England on the move to an all graduate entry to nursing had examined the views of the students themselves.

When considering how the research aim and outcomes could best be met, a range of quantitative and qualitative data collection methods were considered relevant. This influenced both the design and the methodology used. An inductive reasoning approach (Gray, 2009) was taken. As Moule and Goodman (2009, p.173) state, inductive reasoning, "is a process of starting with the observations and details of an experience, our observations of something, that are used to develop a general understanding of a phenomena." According to Gray (2009) such observations may lead to the identification of relationships, the construction of generalizations and possibly the development of theories.

As with any empirical research this study had to be embedded within an appropriate perspective. Crotty (1998, p.4) includes a useful diagram outlining the relationship

between epistemology, theoretical perspectives, methodology and methods (Figure 4.1). The remainder of this chapter will be based on this diagram, providing an overview of the design that underpinned this study. Figure 4.1 suggests a linear progression from epistemology through to methods. However, Crotty (1998) provides further details and examples of these sections in the reverse order, i.e. starting with methods and finishing with epistemology. He suggests that the arrows can move in all directions, stating, "Not too many of us embark on a piece of social research with epistemology as our starting point. 'I am a constructionist. Therefore, I will investigate …' Hardly," (Crotty, 1998, p.13).

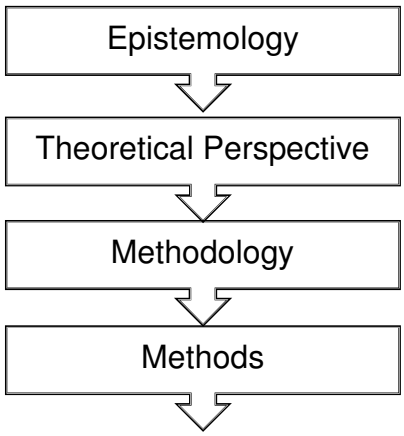

Figure 4.1: Four elements of social research (adapted from Crotty, 1998)

Crotty (1998) further suggests that a study will often start with an issue that needs to be addressed, a real-life problem that needs to be solved or a question that needs to be answered. The researcher should define the aims and objectives of the study based on the issue, problem or question. This will lead them to a suitable methodology and methods for data collection. However, the researcher will need to justify the methodology and methods chosen. It is within a theoretical perspective and epistemology that the researcher can provide this justification and defence. Punch (2014) suggests that there are two main approaches when planning a research project, the *paradigm-driven* approach where the researcher starts with the paradigm (theoretical perspective to use Crotty's (1998) terminology) and develops research questions and appropriate methods from and within the perspective of this paradigm, or the *pragmatic approach* where the researcher begins with research questions and chooses appropriate methods for answering them. Punch (2014) supports the premise that appropriate methods of data collection, influenced by the research

question, are the first consideration of research design, stating that, “too often in the past … we have put the methodological cart before the substantive (or content) horse,” (p.7). This pragmatic approach starting with methods describes the process taken in relation to this study. Although not strictly adhering to Crotty’s (1998) diagram, the methods (questionnaire and focus group) were chosen for pragmatic reasons, and a combination of the methods and the theoretical perspective (constructionism) influenced the choice of methodology (case study) for the study. Each section of Crotty’s (1998) diagram is presented below providing further details and some rationale for the choices made for the current study. The order they are presented reflects the order of consideration in the design of the study.

4.2 Methods

Crotty (1998) describes research methods as concrete techniques or procedures. He states that researchers should be specific in describing their methods. Data for this study was collected using questionnaires and focus groups. According to Anthony and Jack (2009) collecting data from multiple sources (data triangulation) enhances authenticity. Data triangulation has also been advocated as a way of increasing the internal validity of a study, i.e. the extent to which the method used is appropriate in answering the research question (Crowe *et al*., 2011).

It was anticipated that aspects of the programme would be discussed and evaluated by both students and educators, however, it was not the intension of the study to undertake an evaluation of the BSc (Hons) Nursing Studies programme itself. According to Gray (2009, p.278), “Evaluation involves the systematic collection of data about the characteristics of a programme, product, policy of service.” Evaluation is about exploring what needs to change, how the change will be implemented and what evidence will be collected to identify if the change has occurred (Gray, 2009). Frameworks for evaluation such as the approach proposed Kirkpatrick and Kirkpatrick (2006) were not considered appropriate for the current study.

4.2.1 Sampling

The aim of the study and the research question provided a general reference boundary or frame (Swanborn, 2010) for sampling. By definition, the participants had to be pre-

registration nursing students on an all graduate programme based in England, the nursing educators involved in the education of these students, or other Allied Health Professional (AHP) educators. However, as Miles and Huberman (1994, p.27) state, "you cannot study everyone everywhere doing everything." The frame needed to be refined. The decision was taken to focus on one English university and to study the first all graduate pre-registration nursing programme held there. The university was chosen for a number of reasons. Stake (1995) suggests that case study research is not sampling research, as the primary aim is to understand the case being studied, and not to understand other cases. A case may be selected on the basis of it being typical or representative of other cases. According to the Universities and Colleges Admissions Service (UCAS) the university where the study was based was one of over 70 providers in England that offered pre-registration nursing programmes (UCAS, 2014). It had offered pre-registration nursing programmes (diploma and degree) for many years following the amalgamation of several Schools and Colleges of Nursing. The decision was also made for pragmatic reasons (Swanborn, 2010) as it was the institution where I was based. As such the institution, students and educators were 'conveniently available' (Polit & Beck, 2008). Once the location for the study had been selected, purposive sampling was used to limit the participants to those relevant to the research question. Anthony and Jack (2009) identified that most studies included in their integrative review of case study research in nursing used purposive sampling. If the university was considered typical of other institutions where pre-registration nursing is offered, then the students and educators at that university should also be considered as typical of students and educators at other universities.

4.2.2 Data collection from BSc (Hons) Nursing Studies students

Students from the BSc (Hons) Nursing Studies programme at the university where the study was based, who commenced in September 2012 were invited to participate. Although purposive sampling was used to identify the cohort, students within the cohort were not 'hand-picked' as every student was given equal opportunity to participate. The whole cohort was provided with a background to the study, and students were able to discuss their participation and any questions they had directly with myself. The students were informed that a link to a questionnaire would be sent out via their student email accounts. The questionnaire was available via the *Bristol*

Online Survey (BOS) platform. The body of the email provided written information regarding the study. The first page of the questionnaire was an information sheet and the second page a consent form. Students who agreed to participate in the study were asked to give their opinions, based on a five point Likert Scale (Strongly Disagree to Strongly Agree), to 29 statements adapted from the *Nursing Attitude Questionnaire* previously used by Toth, Dobratz and Boni (1998) and Bolan and Grainger (2009). The questionnaire examined attitudes towards nursing using statements that reflect the characteristics of nurses and nursing, nursing roles and values, and professionalism (Bolan & Grainger, 2009). The questionnaire from the current study also asked the participants to write about why they wanted to become a nurse and what they thought the role of a Registered Nurse (RN) in their chosen field of nursing was.

Despite several reminders being sent via email around four weeks and six weeks after the initial email, the overall response rate was 11.2%. All emails were forwarded to the students' individual accounts by the relevant Course Assistant. For the first reminder, the Course Assistant was asked to monitor the 'read receipts' for the email sent. Emails were sent out to 187 students. Some 48 hours later, 50 read receipts had been received. Although it would be very difficult to quantify, a question remains as to how many students did not access their email accounts at all. It is therefore difficult to conclude that the low response rate was a result of the students not wanting to participate, when there was a significant majority who, at least within a reasonable time frame, had not accessed their student email account. This is an important limitation when using email as the media for participants accessing a questionnaire. Students are encouraged to access their student email accounts on a regular basis, and there are systems in place that can forward emails from a student's university mailbox to their personal email account, but there is no guarantee that students are using these facilities.

In view of the low response rate a second occasion was arranged. Instead of distributing the questionnaire via *BOS*, a paper copy was handed out during the induction to Year 2 sessions. The questionnaire was distributed by the Year Leader and students were invited to complete the questionnaire immediately. An information

sheet and a consent form were included. The students were under no obligation to complete the questionnaire, and no coercion was applied. Polit and Beck (2008) suggest that this approach to questionnaire distribution should maximise the number of completed questionnaires. However, at short notice, I was unable to be present. A response rate of around 30% was achieved, and I was later informed by the members of the student focus group that the questionnaires had been distributed along with other forms and there simply had not been sufficient time to complete them. Therefore, I took the decision to discard the questionnaires obtained (no analysis had been undertaken) and arrange a third attempt to distribute the questionnaire. This was done at the end of a taught session and achieved a response rate of 88%. This was somewhat of a compromise as the questionnaire was finally distributed around eighteen months into the course and this may well have impacted on the answers students gave to the free text questions.

Focus Groups

A further email was sent out to the whole September 2012 cohort (n = 187) inviting expressions of interest to join a focus group to investigate their experiences on the programme. The first focus group meeting was arranged for 11 December 2012. This date was chosen specifically as the students were already attending the University and therefore did not have to incur extra expenses travelling in. Following a reminder email, expressions of interest were obtained from four students, one from each field of nursing. The focus group meeting was facilitated by a moderator other than myself who followed a question guide (Chapter five) based on recommendations by Kruger and Casey (2000) and their *Categories of Questions*. The rationale for using a moderator was because I had already taught the September 2012 cohort before the study commenced. I would be involved in more teaching throughout year one and was associated with a module in year two so would have significant exposure to the adult field students. In short, I was known to many of the students. The moderator was a Head of Division and would not be involved in any teaching to the cohort until after data collection had finished. I met the four group members, gained written consent from them and introduced them to the moderator. I was not present during the first meeting. The discussions were audio-recorded and transcribed verbatim by myself. I experienced some difficulty in identifying some of the individual participants.

As a result, the decision was taken that for subsequent focus group meetings I would be present, sitting away from the group members and moderator to make a record of the order of contributors. I explained the reason for my presence and did not participate in the discussions at all. This greatly assisted the transcribing process.

Focus group meetings were also held:

1. Following the students' first clinical placement in year one (23 April 2013)
2. Following their second clinical placement in year one, at the start of year two (10 October 2013)
3. Following their third clinical placement, towards the end of the main theory block for year two (24 February 2014)

On each occasion the focus group discussions were audio-recorded and transcribed verbatim by myself.

4.2.3 Data collection from educators

A questionnaire developed for an earlier study (Prescott, 2010), modified to enable AHP educators to identify their professional background was sent to educators (Lecturers, Senior Lecturers, Principal Lecturers, and Readers) from all Divisions within the Department of Health Sciences at the University where the study was based. A total of 67 educators were invited to participate, 28 nursing and 39 AHPs. These included midwifery, occupational therapy, operating department practice, physiotherapy and podiatry. AHPs were included for three main reasons. Firstly, one of the arguments in favour of the move to an all graduate entry to nursing was parity with other allied health professions. Secondly, there was increased emphasis on inter-professional learning and working in the new curriculum. Finally, many Registered Nurses work inter-professionally and I felt it was important to investigate the attitudes and perspectives of some of these AHPs. Midwifery was bracketed with the Allied Health Professions for ease of reference and to distinguish it from nursing, although it is acknowledged that midwifery is closely associated with nursing and that midwives, like nurses are registered with the NMC.

The questionnaire was available via *BOS* and a link to it was sent via email to the individual university staff accounts. The questionnaire was 'open' for thirteen weeks

(05 November 2012 – 03 February 2013). Reminder emails were sent after four weeks and twelve weeks. Final response rates were 71.4% for nursing academics and 38.5% for AHP academics.

Nursing educators directly involved in the teaching and academic support of pre-registration nursing students on the new curriculum were invited to join a focus group. The purpose of this focus group was to explore their experiences of teaching and supporting nursing students from the September 2012 cohort.

4.2.4 Focus groups

Barbour and Kitzinger (1999) suggest that focus groups are an ideal method for exploring participants' experiences, opinions, wishes and concerns. Kruger and Casey (2000) suggest that a 'typical' focus group has five characteristics:

1. People who
2. possess certain characteristics and
3. provide qualitative data
4. in a focused discussion
5. to help understand the topic of interest.

As fewer than six participants expressed an interest to join the student focus group, the group became a 'mini-focus group' (Kreuger, 1994). Kruger and Casey (2000) suggest that a mini-focus group may be a distinct advantage in terms of logistics. Kitzinger and Barbour (1999) state that many of the contributors to their book (Barbour & Kitzinger, 1999) worked with group sizes of five or six, even as few as three. The group did have one member from each of the four fields of nursing, so there was a degree of 'representativeness' from the whole cohort. Bazeley (2013) suggests that researchers should identify why they chose to gather data using focus groups rather than individual interviews. The purpose of the focus group was to explore the students' experiences at different stages throughout the programme. These experiences would be individual, but a focus group was chosen rather than individual interviews to stimulate discussion between the participants on both their *common* and *unique* experiences. As such, the goal was not necessarily to obtain consensus at the end of each meeting. Willis, Green, Daly, Williamson and Bandyopadhyay (2009) writing from a public health research perspective refer to the importance of the interaction between participants in a focus group. They suggest,

> In interpreting the data (both content and interaction), the analyst is less concerned with whether the information presented by participants is 'objectively true', and more interested in the way that such information is presented and received within the group and how group interaction may challenge or confirm people's stated views.
>
> (Willis *et al.*, 2009, p.134)

The use of the term 'objectively true' is interesting. The purpose of this part of the study was to obtain a degree of 'truth' about the students' experiences. That truth was, in many cases individual, and as such would only be 'true' to one participant, at that time, and there was no real way to verify the 'truth', but the emphasis was on the information obtained from the participants. Data on group interaction was collected, but this supplemented the information obtained by the participants providing some context for how/when the information was obtained and was not, as Willis *et al.* (2009) would suggest, the main interest or purpose of the analysis. Each group member was asked to reflect on their experiences following the final focus group meeting. This reflection was individual and written.

The nurse educator focus group was held after the September 2012 cohort had been on the programme for two years. Some potential participants who had expressed an interest to attend the focus group meeting were unable to attend at short notice. This resulted in there being four members of staff present, representing two of the four field of nursing. This was a limitation, however, three participants held leadership positions on the new programme and the fourth had been the programme leader for the previous programme, therefore I felt there was wealth of experience and knowledge across the whole programme amongst those present.

4.2.5 Educator questionnaire design

Questionnaires are research tools used so that the sample selected can respond to the same set of questions in a predetermined order (Gray, 2009). They offer an objective means of collecting data on, amongst other aspects, people's attitudes (Boynton & Greenhalgh, 2004). Gray (2009) cautions against the belief that questionnaires are easy to design.

The Likert scale as the response option was chosen because it is an approach that allows respondents to indicate how strongly they agree or disagree with a number of statements (Gray, 2009). Secondly, it is a commonly used approach familiar to many across a wide variety of health, social care, educational and business backgrounds (Gray, 2009; Holt, 2009; Punch, 2009; Ryan & Garland, 1999).

The final design incorporated a number of suggestions from relevant literature. For example, Ryan and Garland (1999) promote the use of a no-response option, suggesting that sometimes people genuinely have no opinion. Statements were chosen that expressed both a positive and negative view of the move to an all graduate entry. This approach is recommended by Rattray and Jones (2007) to minimise the possibility that some respondents would respond in the same way to each statement, described by Boynton and Greenhalgh (2004) as '*yea sayers'*. Statements were kept relatively brief (Meadows, 2003) and double negative or double-barrelled questions were avoided (Rattray & Jones, 2007). This necessitated some editing of the statements, but care was taken to maintain the context and implications of each from the original. A free text option was included (Rattray & Jones, 2007) and demographic details were kept to the end of the questionnaire (Meadows, 2003; Rattray & Jones, 2007).

The statements used in the questionnaire were based on responses posted on the *Nursing* Times website following two articles published on there (Bernhauser, 2010; Fleming 2009). The relevant sections from the *Nursing Times* website were first printed off and the initial two threads and each subsequent entry were read carefully. Following initial reading, the whole accounts were re-read and key phrases highlighted. These key phrases were then further reviewed and became the basis of each of the statements included in the questionnaire.

The initial questionnaire contained 24 statements. Following review by three senior colleagues this was reduced to 20. One question was removed as it was felt to be too emotive. One was removed because it was felt by the reviewers to contain an assumption. It read 'nursing does not need a workforce qualified to degree level when basic care so often gets missed'. The point of basic care being missed was clearly

the opinion of the original author of the post on the message board, however the reviewers felt its inclusion in the questionnaire suggested that this was the accepted norm. The other two questions were removed as they were felt to be confusing. The remaining questionnaire (Appendix 1) was then subject to a small pilot study and no further changes were recommended.

4.2.6 Student questionnaire design

The student questionnaire was based on the previously validated *Nursing Attitude Questionnaire* as used by Toth *et al.* (1998), and Bolan and Grainger (2009). Toth *et al.* (1998) sought to investigate if there were any differences in the attitudes towards nursing of traditional nursing students (typically aged between 17 and 22 who often entered the nursing programme immediately after high school) and graduates earning a second degree in nursing at three different universities across the United States of America. Prior to the study they had noted an increase in the number of graduates pursuing a second degree in nursing. During a review of the literature to identify instruments used to measure attitude towards nursing, the researchers identified a 'nursing views questionnaire' developed by L.M. Hoskins in 1983. The Hoskins questionnaire was a twenty item, five-point Likert scale instrument. Toth *et al.* (1998) adapted some items and added an additional ten, developing the 30 item *Nursing Attitude Questionnaire*. Content validity was supported by a panel of experts and Cronbach alpha was 0.80 on the whole questionnaire. Bolan and Grainger (2009) used the *Nursing Attitude Questionnaire* as part of their study, based in Canada investigating whether the perception of nursing students changed over the course of their programme.

Although the questionnaires were designed for a North American context, and the original questionnaire was designed nearly twenty years prior to the current study, key areas, such as nursing roles, values, responsibilities, characteristics, professionalism and the view of society towards nursing, were appropriate to the current study and time. For the current study, the *Nursing Attitude Questionnaire* was adapted, by 'anglicising' the content and removing one statement (number 27) that was considered to be inappropriate to the current study and climate.

Table 4.1: Adaptations made to Nursing Attitude Questionnaire devised by Toth *et al.* (1998) and Bolan and Grainger (2009)

Statement	Original	Revised
1	Nurses are patient's advocates	Nurses are advocates for the patients/clients
2	Nurses protect patients in the health care system	Nurses protect patients/clients in the health care system
3	Nurses participate in the development of health care policies	Nurses participate in the development of health care policies
4	Nurses should wear a white uniform in order to be identified	Nurses should wear a uniform in order to be identified
5	Nurses act as resource persons for individuals with health problems	Nurses act as resource persons for individuals with health problems
6	Nurses in general are kind, compassionate human beings	Nurses in general are kind, compassionate human beings
7	It takes intelligence to be a nurse	It takes intelligence to be a nurse
8	The service given by nurses is as important as that given by physicians	The service given by nurses is as important as that given by doctors.
9	Everyone would benefit if nurses spent less time in school and more time caring for patients	Everyone would benefit if nurses spent less time in school and more time caring for patients
10	Nurses integrate health teaching into their practice	Nurses integrate health teaching into their practice
11	Research is vital to nursing as a profession	Research is vital to nursing as a profession
12	Nurses are politically active	Nurses should be politically active
13	Nurses are capable of independent practice	Nurses are capable of independent practice
14	Nurses speak out against inadequate working conditions	Nurses speak out against inadequate working conditions
15	Nurses are compensated sufficiently for their work by the knowledge that they are helping people	Nurses are compensated sufficiently for their work by the knowledge that they are helping people
16	Nurses should have a right to strike	Nurses should have a right to strike
17	Nurses follow the physician's orders without questions	Nurses follow the doctor's orders without questions
18	Men make good nurses	Men make good nurses
19	Many nurses who seek advanced degrees in nursing would really rather be physicians	Many nurses who seek higher degrees in nursing would really rather be doctors
20	Nursing is exciting	Nursing is exciting
21	Nurses incorporate research findings into their clinical practice	Nurses incorporate research findings into their clinical practice
22	The major goal of nursing research is to improve patient care	The major goal of nursing research is to improve patient care
23	Nurses are adequately paid for the work they do	Nurses are adequately paid for the work they do
24	Nurses value time at the bedside caring for patients	Nurses value time at the bedside caring for patients
25	Nurses should have a baccalaureate degree for entrance into practice	Nurses should have a degree for entrance into practice
26	Nurses with advanced degrees make important contributions to patient care	Nurses with higher degrees make important contributions to patient care
27	One advantage to being a nurse is to marry a physician	Statement removed
28	Nursing is a respected profession	Nursing is a respected profession
29	Nurses consistently update their practice in relation to current health trends	Nurses consistently update their practice in relation to current health trends
30	Nurses feel good about what they do	Nurses feel good about what they do

The details of the original questions and how these were adapted is shown in Table 4.1 below. See appendix 2 for the questionnaire used for this study.

4.2.7 Ethical considerations

This study was designed and undertaken in accordance with the British Educational Research Association's (BERA) ethical guidelines for educational research (BERA, 2011). Participants were assured that all data would be protected and stored securely (BERA, 2011, paragraphs 25 – 28). All data files stored electronically were password protected. Paper based data were stored in a locked cabinet in my office. Only I had access to the raw data. The study was approved by the School Research and Ethics Panel (SREP) of the School of Human and Health Sciences where the study was based. This approval permitted access to the relevant students and members of academic staff. Following SREP approval, permission to access the students and academic staff was granted by the Head of Undergraduate Nursing and Head of Department respectively.

4.2.8 Informed consent

Informed, written consent was obtained from all participants at each stage of the study. All participants were given an information sheet which included information on the study, how data would be used, and outlined the individual participant's right to withdraw at any stage. For the students, the information sheet also confirmed that their continued place and experiences on the course would not be affected in any way by their decision to participate (or not), or their decision to withdraw from the study if they wished to do so. Participants were assured that their involvement in the study was entirely voluntary. At each focus group meeting I reminded the participants of the purpose of the study and their right to withdraw from it at any stage. Consent was gained at the start of each focus group meeting; there was no presumption that consent to participate at one meeting implied consent for them all.

As the study was undertaken at the University where I worked, overcoming any risk of coercion was considered throughout. To this end, each focus group meeting was facilitated by a colleague who, although a senior academic in nursing, would not have any direct contact with the students until later in their programme.

4.2.9 Anonymity

For the questionnaires, no personal identifiable information was submitted. Participants were assured that anonymity would be maintained throughout the study and in any subsequent publications.

4.2.10 Psychological trauma

Whenever past events are discussed by participants there remains the potential that recalling these experiences may cause upset. Both the facilitator of the focus group meetings and myself are experienced nurses and were confident in dealing, at least initially, with any such incidents if they arose. The University where the study was based has robust mechanisms in place to support students and these would have been signposted if required. No participant showed any sign of distress during any of the meetings. Indeed, on reviewing the process after the final student focus group meeting, all the participants commented on what a beneficial and therapeutic experience it had been.

4.2.11 Data analysis

Data analysis has been defined as, "the process through which researchers manage the collected data to identify key patterns or features that are important when answering (or attempting to answer) research questions," (Gilchrist & Wright, 2009, p.323). Approaches to and methods for data analysis reflect the type of data and how it was collected. The methods used and scope of data collected in the current study necessitated both quantitative and qualitative approaches to analysis.

<u>Analysis of quantitative data</u>

There has been a great deal of debate regarding the nature of data produced using Likert scales and therefore what statistical tests are appropriate (Carifio & Perla, 2007; Carifio & Perla, 2008; Jamieson, 2004; Pell, 2005). Jamieson (2004) accepts that the response categories in a Likert scale have a rank order, but that the intervals between each category cannot be assumed equal and as such, the data is ordinal and non-parametric tests should be employed. Pell (2005, p.970) disagrees, suggesting,

> It is acceptable in many cases to apply parametric techniques to non-parametric data such as that generated from Likert scales, provided that the assumptions are clearly stated, and that the data is of the appropriate size and shape.

No clues are given as to what constitutes 'the appropriate size and shape'.

Carifio and Perla (2008) suggest that the debate around how the data generated from Likert scales should be analysed has been on-going for over 50 years. They state, "Likert items are not ordinal in character, but rather are interval in nature and, thus, may be analysed parametrically with all the associated benefits and power of these higher levels of analyses," (Carifio & Perla, 2008, p.1150).

For the current study, mean scores for each statement were calculated and comparisons of the scores were made across the fields of nursing. In doing so, the Likert scale was considered interval. However, the debate surrounding the nature of data obtained using Likert scales was noted. Therefore, like Cowin and Johnson (2011), statistical significant differences between variables were calculated using the Kruskal-Wallis H Test (non-parametric) as well as one-way ANOVA (parametric) to adjust for these issues. Both the Kruskal-Wallis H Test and one-way ANOVA are recommended when there are more than two samples (Argyous, 2011). For the current study, four samples were used, linked to the four fields of nursing. The Tukey HSD test was undertaken where one-way ANOVA identified a statistical difference ($p = <0.05$) and Bonferroni Correction was calculated to adjust for variance in the number of respondents in each group. The Bonferroni Correction corrects for multiple tests against multiple variables and therefore reduces the likelihood of Type 1 errors (assuming an effect when there is not one) but increases the likelihood of Type 2 errors (assuming there is not an effect when there is one). In short, the Bonferroni Correction reduces the alpha value to make a chance finding less likely (Armstrong, 2014). As with any data analysis, the findings should be read considering the approaches used.

This level of data analysis was undertaken for the student questionnaire. Due to the low number of participants for the nurse educator and AHP educator questionnaires,

it was considered inappropriate to seek statistical significant differences across the different groups.

For the Likert scale section of each questionnaire, the following weighting was used to aid analysis.

- A response of strongly disagree scored 1 point.
- A response of disagree scored 2 points.
- A response of neutral scored 3 points.
- A response of agree scored 4 points.
- A response of strongly agree scored 5 points.

SPSS version 22 (IBM®) was used to aid analysis.

Analysis of qualitative data

There were several factors that could have influenced the approach to data analysis for this study. One influence was the chosen methodology: case study. Swanborn (2010, p.115) outlines five traditions for data analysis within case studies:

1. Analysis of data collected in the field of changing organisations.
2. Analysis of data collected in one of the qualitative traditions.
3. Data analysis, and especially data presentation based on the work of Miles and Huberman (1994).
4. Time series analysis.
5. Data analysis using Boolean logic and fuzzy-set theory (Ragin, 1987, cited in Swanborn 2010, p.89).

The second influence was one method of data collection; focus groups. Duggleby (2005) suggests that there has been a significant lack of literature on, "the methodological analytic issues of focus group data," (p.834). Barbour (2005) indicates that focus group analysis involves much the same processes as the analysis of other qualitative data, but recognises that there are additional challenges with the analysis of focus group data. Barbour (2005) argues that analysis of data obtained through the use of focus groups should be, "congruent with the qualitative tradition," (p.748).

Ilic and Forbes (2010) in their study on undergraduate medical students' use and perceptions of evidence-based medicine used focus groups as a method of data collection. Their section on data analysis indicates that transcripts were independently analysed by two researchers using thematic analysis with the aid of NVivo® software. Duers and Brown (2009) in their study on student nurses' experiences of formative assessment offer only brief details of their data analysis but hint at thematic analysis. Similarly, Halkett and McLafferty (2006) include only one sentence on data analysis where they state that data were analysed thematically, but include no details on how this was done. Whilst journal constraints on word count have undoubtedly had an impact, this lack of detail on data analysis techniques is unhelpful and supports Duggleby's (2005) accusation that data analysis is rarely discussed in any detail in focus group research reports.

Rosenberg and Yates (2007, p.448) suggest that data collection techniques in case study research should be, "pragmatically – rather than paradigmatically – driven." The same could be said for the analysis of the data. The overriding principle for the current study was to identify the emerging themes from each focus group and the free text responses from the questionnaires. Line by line coding was undertaken using NVivo® 10 for Windows (QSR International) to aid the process. As DiCicco-Bloom and Crabtree (2006) suggest, software packages like NVivo® do not analyse the data, but can be a useful aid to the researcher in data management and the analysis process.

Thematic analysis

Thematic analysis was chosen as the method for analysing the qualitative data obtained from the free text sections of the questionnaires and the content of each focus group. It is defined as, "a way of seeing," (Boyatzis, 1998, p.1), and, "a method for identifying, analysing and reporting patterns (themes) within data," (Braun & Clarke, 2006, p.79). According to Boyatzis (1998) thematic analysis allows the researcher to translate qualitative information into qualitative data, code the qualitative data and communicate the data to a wider audience. Boyatzis (1998) further outlines a number of skills required by the researcher undertaking a thematic analysis, namely pattern recognition, openness and flexibility, planning and systems thinking, and tacit knowledge. According to Boyatzis (1998, pp.7-8) the researcher must be able to, "see

patterns in seemingly random information," with an openness that, "must be sustainable," be able to, "organise [their] observations and identified patterns into a *useable system* for observation," (original emphasis), and have, "knowledge relevant to the arena being examined," a competence defined as, "crucial."

Braun and Clarke (2006) suggest that the researcher needs to determine the type of analysis they want to undertake and outline some key decisions that the researcher should make. They state that many research papers fail to explicitly discuss these decisions and how they apply to the particular study. What follows are the decisions taken in relation to these key questions regarding this study.

Decision One: What counts as a theme?

Braun and Clarke (2006) state that a, "theme captures something important about the data in relation to the research question and represents some level of *patterned* response or meaning within the data set," (p.82, original emphasis). Their paper debates what size a theme needs to be in order to be included and what the frequency of occurrence across the data set should be, suggesting that there are no hard and fast rules. The researcher should adopt a flexible approach to identifying themes. The key aspect is not quantifiable measures such as size and prevalence, but whether the theme, "captures something important in relation to the overall research question," (Braun & Clarke, 2006, p.82). As Fereday and Muir-Cochrane (2006) argue, content analysis was not the aim, therefore a single comment was considered as important as those that may have been agreed or repeated by other participants.

Decision Two: A rich description of the data set, or a detailed account of one particular aspect

The researcher should decide whether the aim is to provide a description of the entire data set, providing the reader with information regarding the predominant themes *across* the whole data set, or focus on one particular theme or group of themes *within* the data set (Braun & Clarke, 2006). This study took a 'rich description of the entire data set' approach.

Decision Three: Inductive versus theoretical thematic analysis

For the inductive approach, themes are derived directly from the data and as such may bear little direct relationship to any of the questions asked. In addition, the themes are not linked to any coding frame that the researcher developed before analysis began. The analysis is data driven. Theoretically driven thematic analysis is directed by the researcher's own theoretical interest in the area of study (Braun & Clarke, 2006). Inductive analysis was undertaken within the current study and a coding framework was not used.

Decision Four: Semantic or latent themes

Braun and Clarke (2006) outline another decision that needs to be taken by the researcher undertaking thematic analysis, namely the level at which the themes will be identified. They discuss two levels, 'semantic' and 'latent', referred to by Boyatzis (1998) as 'manifest' and 'latent'. Firstly, at the semantic level the themes are identified explicitly from what the participants have said or written. There is some degree of interpretation, perhaps using previous literature as a guide, where the researcher can theorise the significance of the patterns of themes that have emerged (Braun & Clarke, 2006). Thematic analysis at a latent level goes beyond this and the researcher will aim to identify the, "*underlying* ideas, assumptions, and conceptualizations - and ideologies - that are theorized as shaping or informing the semantic content of the data," (Braun & Clarke, 2006, p.84, original emphasis).

For the current study, the themes were initially identified at the semantic level, but some interpretation of these did move beyond this and aimed to identify some of the underlying ideas and assumptions.

Decision Five: Epistemology: essential/realist versus constructionist thematic analysis

The epistemological background to this study, namely constructionism, is discussed in section 4.5 below. Braun and Clarke (2006) suggest that thematic analysis undertaking within a constructionist framework will seek to, "theorise the sociocultural, and structural conditions, that enable the individual accounts that are provided," (p.85), and further suggest that analysis that focuses on themes at a more latent level would tend to suggest a constructionist approach. Underpinning this study are the

sociocultural conditions influencing the students' and educators' experiences of the programme.

Phases of thematic analysis

The framework for undertaking a thematic analysis devised by Braun and Clarke (2006) was utilised in this study. They outline a six phase approach (Table 4.2).

Table 4.2: Phases of thematic analysis (adapted from Braun & Clarke, 2006, p.87)

Phase	Description of the process
1. Familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

The decision was taken to code each data set separately, identifying the codes and themes for each before any attempt was made to devise themes across the whole data corpus.

Each focus group meeting was audio-recorded and transcribed verbatim by myself. Each transcription was checked on three separate occasions for accuracy before any formal analysis was undertaken. Although the transcribing process did allow me to become familiar with the data, the focus was on creating an accurate transcription rather than on any initial analysis. Each transcript was then read straight through twice. Key points were listed during a third read through and a short paragraph, summarising the key points was written after a fourth read through, completing phase one of Braun and Clarke's (2006) six stage approach. Free text responses to the student and educator questionnaires were typed up verbatim. These too were read through following the process outlined above.

4.3 Theoretical perspective

Crotty (1998) defines the theoretical perspective as, "the philosophical stance lying behind a methodology," (p.66). Weaver and Olson (2006) use the term 'paradigm' to illustrate what Crotty (1998) refers to as 'theoretical perspective', and identify the confusion that can arise through the use of different terms, highlighting those such as 'disciplinary matrix', 'worldview' and 'research tradition' as alternatives used in research literature. Crotty (1998) acknowledges that a researcher will inevitably bring a number of assumptions to the chosen methodology. The theoretical perspective provides a structure for these assumptions to be placed 'in-context'. Examples of theoretical perspectives include positivism, post-positivism, critical inquiry, feminism and interpretivism. Interpretivism underpinned this study and will be discussed first.

4.3.1 Interpretivism

Interpretivism is often linked to the work of Max Weber (1864-1920) who suggested that the human (or social) sciences are concerned with *Verstehen* (understanding), as opposed to the natural sciences approach of *Erklären* (explaining) (Crotty, 1998). Interpretivism emphasises that social reality and natural reality (including the laws of science) are different and therefore require different methods of inquiry. The natural sciences strive for consistency and laws whereas the social sciences deal with the actions, attitudes and experiences of the individual (Crotty, 1998; Gray, 2009). Interpretivism focuses on the meanings that individuals bring to situations, experiences and behaviours that they use to make sense of their world (Punch, 2014) and as such relies on a particular context such as the timing, meanings and intentions (Benner, 1984).

Gray (2009) outlines five examples of interpretive approaches; symbolic interactionism, phenomenology, realism, hermeneutics and naturalistic inquiry. Both Crotty (1998) and Gray (2009) point to the American influences on the development of symbolic interactionism, not least the work of the social psychologist, George Herbert Mead (1863-1931). The essential principles of symbolic interactionism are that:

- People interpret the meaning of objects and actions in the world and then act upon these interpretations.

- Meanings arise from the process of social interaction.
- Meanings are handled in, and modified by, an interactive process used by people in dealing with the phenomena that are encountered.

(Gray, 2009, p.22).

These meanings are not fixed or stable and will change in the light of new experiences, including a new or developing perspective of 'self'. Any research study will need to be based from the perspective of the participants themselves. As Crotty (1998, p.8) outlines, the ability to put yourself in the place of others lies at the heart of symbolic interactionism. This is likely to require time observing the participants first-hand (Gray, 2009). This data collection method has clear links with ethnography, which is considered to be a research methodology based on symbolic interactionism (Crotty, 1998; Gray, 2009). The current study did not utilise participant-observation as a data collection method.

Phenomenology is rooted in the philosophical tradition developed by Edmund Husserl (1859-1938) and Martin Heidegger (1927-1962). Phenomenology aims to explore people's everyday lived experiences recognising that these lived experiences are a source of powerful data (Moule & Goodman, 2009). Phenomenology asserts that the 'world' exists within the consciousness of individuals and all their actions and interactions have a meaning within that world (Sadala & Adorno, 2002). As well as the influence of the individual, these 'meanings' are also a construction of the society in which they live (Barkway, 2001), therefore any understanding of an individual's lived experiences cannot be separated from relevant culture, history and traditions (Johnson, 2000). The objective of phenomenology is to describe the lived experience or what the experience meant to those living it. Phenomenology is concerned with 'perception' and 'meaning', not measurement and cause (Paley, 2005).

A particular approach to phenomenology known as 'interpretive' was developed by Heidegger. Heidegger was a student of, and later became an assistant to, Husserl (Holloway & Wheeler, 2002; Moule & Goodman, 2009; Ray, 1994). Heidegger sought to understand phenomena rather than just describe them (Johnson, 2000; Maggs-Rapport, 2001; Moule & Goodman, 2009). He devised the term 'being-in-the-world' rather than his description of Husserl's approach as 'being-of-the-world' (Ray, 1994).

Interviews, diaries, autobiographies, written accounts and conversations are some of the methods for data collection employed within phenomenological research (Moule & Goodman, 2009).

Neither Crotty (1998) nor Gray (2009) list case studies under the heading of *interpretive* or *interpretivism*. Gray's (2009) book includes a separate chapter '*Designing case studies*'. The introduction to this chapter hints that case studies usually take a more deductive approach. Gray (2009) does acknowledge that he refers extensively to the work of Yin, so this may help explain the somewhat positivistic description of case studies. Anthony and Jack (2009) suggest that as a research methodology, case studies *are* grounded in the interpretive paradigm.

4.3.2 A brief introduction to other theoretical perspectives

The roots of positivism can be traced back to the French philosopher Auguste Comte (1798-1857) who coined the phrase to designate an approach to science without the need for theological and metaphysical considerations (Goding & Edwards, 2002). Social scientists began to adopt this 'scientific' approach for building knowledge (Punch, 2009) and positivism became the dominant approach used between the 1930s and the 1960s (Gray, 2009). Giddings and Grant (2007) suggest that quantitative research and positivism have historically been viewed as synonymous. Muijs (2004) states that it is inaccurate to label all quantitative research 'positivist', but acknowledges that it can be difficult to separate the two in research literature. The positivist approach believes that there is one absolute 'truth' that can be proven and knowledge derived (deducted) through observations and measurements (Goding & Edwards, 2002; Holt, 2009). This 'absolute truth' is considered independent of human perception (Gray, 2009; Weaver & Olson, 2006). The truth is 'out there' and the purpose of the study is to uncover it (Muijs, 2004). The positivist approach assumes that 'things' in the world can be studied as hard facts and the relationship between these facts can be established as scientific laws (Crossan, 2003). Gray (2009) suggests that, from a positivist perspective, ideas only deserve being incorporated into knowledge if they can be tested in an empirical way. Gray (2009) suggests that there have been many different versions of positivism, which, despite some overlap, rarely agree precisely on the essential components.

Postpositivism is considered to be an extension to, or development of positivism (Giddings & Grant, 2007; Routledge, 2007). The main influences on this approach are the works of Karl Popper (1902-94), Jacob Bronowski (1908-74), Thomas Khun (1922-96) and Norwood Russell Hanson (1924-67) (Clark, 1998; Crotty, 1998). It calls into question the positivist notion of absolute truth, provable hypotheses and researchers that are unbiased and value free (Giddings & Grant, 2007) suggesting that because human phenomena are complex, and individuals are unpredictable, distinct and therefore unrepresentative of the entire group, it is impossible to expect absolute predictability (Routledge, 2007). The postpositivist would therefore seek to 'support' a hypothesis rather than 'prove' it, but would still view scientific methods and principles as the best way to achieve this (Giddings & Grant, 2007). Science is not seen as involving personal experience or opinion, but personal processes and involvement are seen as being features of human inquiry.

4.4 Methodology

Research methodologies will generally fall into two broad approaches, quantitative or qualitative (Crotty, 1998). Moule and Goodman (2009) suggest that historically these two approaches were considered to be in opposition, but recognise that more recently researchers have used a range of approaches to address research questions. Crotty (1998) suggests that the distinction between quantitative and qualitative research occurs at the level of methods; how and what data is collected, a point supported more recently by Punch (2014). The use of the questionnaire suggested a quantitative approach to the study as much of the data was reduced to descriptive statistics. However, the questionnaires also incorporated 'free text' sections which generated considerable qualitative data. The use of focus groups as a method for data collection suggested a more qualitative, interpretive approach.

4.4.1 Case Study

The case study is an established research technique used across a variety of education, health and social care professions (Anaf, Drummond & Sheppard, 2007; Yin, 2009). Rosenberg and Yates (2007, p.447) define a case study as, "a methodologically flexible approach to research design that focuses on a particular

case – whether an individual, a collective or a phenomenon of interest." Similarly, Stake (1995, p.xi) defines a case study as, "the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances." According to Yin (2009, p.18), "A case study is an empirical enquiry which investigates a contemporary phenomenon in depth and within its real life context," and similarly, Bassey (1999, p.47) states that a case study is the, "study of a singularity conducted in depth in natural settings." The definitions presented here provided useful rationale for adopting a case study approach for this study. The aim was to investigate the move to an all graduate entry to nursing as a contemporary phenomenon within its real life context i.e. one English university. The case, identified as the undergraduate pre-registration nursing programme at one English university, was investigated, focusing particularly on the attitudes and experiences of students and healthcare educators. The definition by Rosenberg and Yates (2007) promotes the flexibility of the case study, hinting at the use of both qualitative and quantitative methods and a variety of data collection techniques, which are, "pragmatically – rather than paradigmatically – driven," (p.448). Cousin (2005) and Polit and Beck (2008) agree suggesting that both qualitative and quantitative methods of data collection can be incorporated into a case study. Case study has been described as an approach, a methodology, a strategy and a method of data collection (Anthony & Jack, 2009; Keyzer, 2000; Swanborn, 2010; Walshe, Caress, Chew-Graham, & Todd, 2004). Walshe *et al.* (2004) also state that a case study is not a 'catch all' term for a mixed method approach. For the purpose of this study a case study was defined as 'A methodology involving the empirical investigation of a contemporary phenomenon within a real-world setting using various sources of evidence' (adapted from Keyzer, 2000).

This case study was a single-embedded design (Yin, 2009) with the units of analysis being the nursing students and health professional educators at one English university. The case study was also defined as 'instrumental' (Stake, 1995) as the purpose was to gain insight into a particular issue by studying a particular example. As Luck, Jackson and Usher (2006) suggest, for instrumental case studies, the specific case is important as it will uncover knowledge about the phenomena of interest, which may not be the case itself, but some other external interest.

According to Anthony and Jack (2009, p.1175), case studies have been used to, "describe, explore, understand or evaluate phenomena of interest to nursing, including experiences and perceptions of individuals or a collective." Although the authors were likely to be referring to nursing practice, the move to an all graduate entry was clearly of interest to both nursing practice and education. Yin (2009) offers some rationale for undertaking a single case study. It could be argued that this study was *representative* or *typical* as universities throughout England commenced all graduate programmes during 2012 and 2013. This study could also be described as *revelatory* (Yin, 2009). Although in Wales the degree has been the only entry-level qualification since 2004 (RCN, 2010), the move to an all graduate entry to nursing in England was new. The impact of this change had not been open to investigation. As Stake (1995) states, "We do not study a case primarily to understand other cases. Our first obligation is to understand this one case," (p.4). As such, a case study facilitates a flexible mode of inquiry (Anaf *et al*., 2007), one where the researcher is not limited to producing statistical generalisations, but can focus on investigating the case and examining its meaning (Stake, 1995). Walshe *et al*. (2004, p.677) suggest that, "Case study can use either qualitative [or] quantitative methods, can be prospective or retrospective, can have an inductive or deductive approach to theory, can focus on one case or many, can describe, explain or evaluate." This study was prospective, taking an inductive approach utilising both quantitative and qualitative methods of data collection, focusing on one case with the purpose of describing the attitudes and interpreting the experiences of students and health professional educators.

4.4.2 What is a case?

According to Swanborn (2010) the word 'case' originates from the Latin word '*casus*' (*cadre* = to fall) and means 'event', 'situation' or 'condition'. Yin (2009) suggests that there is a fundamental problem in defining what the 'case' in case study research actually is. Ragin (1992) had previously discussed this issue. Charles Ragin joint-edited a book '*What is a case? Exploring the Foundations of Social Inquiry*' (Ragin & Becker, 1992). The book is a collection of essays presented initially at a symposium organised by Ragin to explore the question 'what is a case'? Ragin (1992, pp.7-8) summarises,

> While the answers to "What is a case?" were diverse, they displayed common themes … They [the participants] agreed that individual social scientists answer the question "what is a case?" in remarkably different ways and that answers to this question affect the conduct and results of the research. And all agreed that cases may be multiple in a given piece of research: what the case is may change both in the hands of the researcher (during the course of the research and when the results are presented) and in the hands of the researcher's audiences.

Defining the 'case' for a particular study is important. Luck *et al.* (2006) suggest that the study itself is defined by what the case is. Similarly, Salminen, Harra and Lautamo (2006) define the 'case' as the object of the study. Luck *et al.* (2006) do acknowledge that it can be difficult to define the 'case' as the term carries a variety of meanings, but suggest that it is a specific phenomenon with particular boundaries of time, place, event or activity. Stake (1995) also introduces the idea of 'boundaries' into his definition of a case, as does Swanborn (2010). Yin (2009) suggests that the case may be an individual, a group of individuals, an event or other entity. For the current study, the case was defined as the BSc (Hons) Nursing Studies programme at one English university with the following relevant boundaries:

1. Students from the September 2012 cohort only (All fields).
2. Educators representing the four fields of Nursing and other related Allied Health Professional programmes offered at the University.
3. September 2012 – September 2014 i.e. the first two years of this three-year programme.

The study involved an empirical unit (rather than theoretical concepts) that existed external to and independent of the study (Ragin, 1992).

4.4.3 Academic criticisms of case study research

Although case study is an established research technique, it is not without criticism, much of it from quantitative researchers (Anthony & Jack, 2009). With a definite leaning towards the positivist paradigm, Yin (2009) discusses what he defines as, "A

common misconception," (p. 6), where research methods should be presented hierarchically. Yin (2009) argues that social scientists who promote this hierarchy view case studies as only appropriate for the exploratory phase of an investigation – experiments being the only way to undertake explanatory or causal inquiries. Yin (2009) suggests that the hierarchy is open to question and presents examples of case studies he defines as 'explanatory', offering some justification for the case study as a methodology for undertaking empirical research. In a section titled '*Traditional Prejudices against the Case Study Method*', Yin (2009) offers four possible objections to case studies. The very use of the word 'prejudice' suggests that Yin (2009) finds these objections to be, not based on reason or actual experience and/or are based on 'bias' rather than fact (Oxford University Press, 2014). Nonetheless, they are presented here to offer a critique of case study as a research methodology. Yin (2009) suggests that the greatest concern relates to the lack of rigour in case study research. Yin (2009), who is, "probably the leading exponent in the social sciences of case study," (Bassey, 1999, p.26), also suggests that often, the case study researcher has been, "sloppy, not followed systematic procedures, or has allowed equivocal evidence or biased views to influence the direction of the findings or the conclusions," (Yin, 2009, p.14). He offers no examples of studies where this has been, in his opinion, the case. He does, however, offer some explanation as to why this might be the case, citing the lack of texts that cover case studies compared with other research methodologies. Keyzer (2000) as part of his review of case studies and their appropriateness for research in rural Australia states, "There is no one blue print for carrying out a case study and therefore there exists a need for rigour in designing the study," (p.269), but offers no information on what this rigour might entail. Flyvbjerg (2006) in his detailed examination of five common misconceptions of case study research suggests the case study approach does have its own rigour, but again, offers no clues as to what constitutes this rigour. Left with this uncertainty, I adopted general principles such as maintaining a diary during the data analysis phase allowing me to reflect on my own position (Cousin, 2005) and an audit trail of key decisions and timings throughout the study (Baillie, 2009; Green, Segrott & Hewitt, 2006). Triangulation, the use of multiple sources and methods for data collection (Salminen *et al.*, 2006) is also viewed as a method of increasing rigour, validity and credibility of a study (Burke & Harris, 2000;

Crowe *et al.*, 2011; Polit & Beck, 2008). Both data triangulation and time triangulation (Polit & Beck, 2008) were used in the current study.

The second concern raised by Yin (2009) is that case studies provide little basis for scientific generalisation. The issue of generalizability is the subject of much debate with Lincoln and Guba (2000) suggesting with the title of their paper that '*The only generalization is: there is no generalization*', and Donmoyer (2000, p.46) who, in the same book argues that,

> Social scientists' traditional, restricted conception of generalizability is consistent with traditional views of applied social science but inconsistent with more contemporary views. Furthermore, the traditional, restricted conception is not only out of sync with contemporary epistemology; it is also dysfunctional because it limits our ability to reconceptualize the role social science might play in applied fields such as education, counselling and social work.

Donmoyer (2000) argues further that research concerned with individuals can never be generalisable in the 'scientific' sense. However, many authors do focus on generalizability and acknowledge that generalisations from single case studies are limited (Anthony & Jack, 2009; Luck *et al.*, 2006; Noor, 2008; Payne, Field, Rolls, Hawker & Kerr, 2007). Stake (1995) suggests that an instrumental case study should not be judged on its ability to produce generalisations. He focuses on 'particularization' rather than generalisation stating that, "The real business of case study is particularization, not generalisation. We take a particular case and come to know it well, not primarily as to how it is different from others but what it is, what it does," (Stake, 1995, p.8). Bassey (1999, p.52) discussing case study research in education, introduces the notion of 'fuzzy generalisations' and states,

> With the scientific generalization there are no exceptions – and indeed in science if any are found then the statement is abandoned or revised to accommodate the new evidence. But in the use of the adjective 'fuzzy' the likelihood of there being exceptions is clearly recognised and this seems an appropriate concept for research in areas like education where human complexity is paramount.

In other words, the researcher should seek to generate predictions that use the term 'may' rather than 'will' (Cousin, 2005). Flyvbjerg (2006) suggests that formal generalization is overvalued and the use of the 'good example' is underestimated.

Yin's (2009) third concern regarding case studies is not really a limitation but an observation; case studies take too long to complete and result in large, unreadable documents. This, he argues, may be due to the fact that case study as a methodology has, on occasions been confused with particular methods of data collection such as participant observation which may require long periods of time. What is supported by other authors is that case studies generally produce a lot of data and the researcher requires skills to manage possibly complex and disparate data (Crowe *et al*., 2011; Payne *et al*., 2007; Salminen *et al*., 2006).

The fourth criticism of case studies that Yin (2009) addresses is the fact that case studies cannot directly address the issue of causal relationships. By way of a defence to this criticism, Yin (2009) suggests that case studies can be used to compliment experiments by offering additional important information, such as the 'how' and 'why' a particular intervention worked or not.

4.5 Epistemology

According to Gray (2009, p.17) epistemology, "provides a philosophical background for deciding what kinds of knowledge are legitimate and adequate." It is about, "how we know what we know," (Crotty, 1998, p.8). There are a range of different epistemologies and as Crotty (1998, p.9) would suggest these are, "not to be seen as water-tight compartments."

Objectivism suggests that there is an objective truth that needs to be identified and that reality exists independent of any consciousness; truth and meaning reside in the object (Crotty, 1998). Research is concerned with identifying this objective truth (Gray, 2009). Positivism is a theoretical perspective linked with objectivism. *Constructionism* purports that there is no objective truth waiting to be discovered, and that truth, or meaning, exists as a result of an individual engaging with the world. It supports the notion that,

> All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context.
>
> (Crotty, 1998, p.42)

There is interaction between the world (object) and the individual (subject). Meaning is not discovered, but constructed, and without a mind or consciousness, there is no meaning. Constructionism would support the notion that different people will construct meaning in different ways, even if they have experienced the same phenomena (Crotty, 1998; Gray, 2009). Crotty (1998) emphasises the element of 'construction' as opposed to 'creation'. The term create would suggest making something from nothing whereas the term 'construct' would suggest making something (perhaps something new or different) from what is already there. Interpretivism is a theoretical perspective linked with constructionism.

Crowe *et al.* (2011) acknowledge that case studies can be approached in different ways depending on the epistemological standpoint of the researcher. They suggest that the researcher may take a critical approach where they question their own and other's assumptions, an interpretivist approach, where they aim to understand individual and shared meanings or even a positivist approach where the researcher will strive for generalizability. This study focused on investigating the attitudes and experiences of individuals, identifying individual and shared meanings, indicating a constructionist/interpretivist approach.

Crotty (1998) identifies a third epistemological stance: *subjectivism*. Here meaning is not constructed as a result of interaction between the object and the subject, but meaning is imposed on the object by the subject, with the object making no contribution to the generation of meaning.

4.6 Conclusion

It would appear that Crotty's (1998) quote regarding the lack of 'water-tight' properties for a particular epistemological approach could be extended to other aspects of research methodology and would suggest that there is no research design that will be

a ‘perfect fit’ for individual research projects, nor is there a ‘one-size fits all’ approach to research design. In addition, different terminology is used by different writers to define the same ideas or concepts leading to further ‘methodological misunderstanding’ or confusion for the novice researcher. Some would argue that researchers must have a real understanding of the philosophical underpinnings of their chosen methodology (Maggs-Rapport, 2001) but this is not helped by a lack of such methodological details and the decisions underpinning the choice of approach in many published papers. Nor is it helped by what Paley (2005) describes as the, “potpourri of ideas,” (p.106) that he discovered when reviewing papers purporting to take a phenomenological approach. Exposure to, and immersion in different approaches will allow the researcher who is building their research portfolio to develop their knowledge and understanding of the underpinning philosophy of various methodologies or research designs. This chapter is written in this context and is not a ‘perfect account’ of a ‘perfect research design’. It has, though, attempted to present the design of the study based on Crotty’s (1998) four stage model, and in doing so provide some rationale for the choices made.

Chapter 5: Results and Findings

5.1 Introduction

This chapter presents the results of all data analysis. Results from analysis of the Likert scale questionnaire data will be presented first in the following order:

1. Student questionnaire.
2. Nurse educator questionnaire.
3. Allied Health Professional (AHP) educator questionnaire.

Thematic analysis of qualitative data will then be presented:

1. Student focus group (first meeting).
2. Student focus group (second meeting).
3. Student focus group (third meeting).
4. Student focus group (fourth meeting).
5. Nurse educator focus group.
6. Student questionnaire.
7. Nurse educator questionnaire.
8. AHP educator questionnaire.

For each of these sections, the narrative will progress through phases one to five of thematic analysis presented by Braun and Clarke (2006) (Table 5.1) as discussed in Chapter four. This chapter fulfils the requirements for phase six.

Table 5.1: Phases of thematic analysis (Adapted from Braun & Clarke, 2006, p.87)

Phase	Description of the process
1. Familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

5.2 Quantitative data: student questionnaire

150 participants across the four fields of nursing (Adult [A] =77, Child [C] =19, Learning Disabilities [LD] =17 and Mental Health [MH] =37) completed the questionnaire (88% response rate). 139 of the respondents were female and six were male (five respondents choosing not to reveal their gender). At the time of completing the questionnaires (18-months into the programme) the respondents had a mean age of 24.6 years (min: 19, max: 46, SD: 6.73, missing data: 12) and 57% identified some previous healthcare experience prior to commencing the programme. Table 5.2 provides further details on the demographic data.

Table 5.2: Demographic details for student respondents

	Field of nursing				
	Adult	**Child**	**Learning Disability**	**Mental Health**	**All**
Number [percentage of total]	77 [51]	19 [13]	17 [11]	37 [25]	150 [100]
Gender					*
Female	75	18	16	30	139
Male	2	1	0	3	6
Mean Age in years					**
[SD]	24.1 [6.21]	20.8 [2.96]	23.5 [3.97]	28.4 [8.55]	24.6 [6.73]
Previous clinical experience					***
Yes [percentage of relevant field]	47 [61]	9 [47]	10 [59]	20 [54]	86 [57]

*5 respondents did not supply data on their gender
**12 respondents did not supply data on their age
***4 respondents did not identify whether they had any previous experience

The Cronbach alpha score across all 29 statements was .616. Some respondents did not provide a response to all 29 individual statements. There was no identifiable pattern to these omissions and therefore the mean score (to zero decimal places) for each individual statement was inputted to replace missing data. The range of total scores across all 150 participants was 88-130, with a mean of 107.2 and a standard deviation (SD) of 7.38. The higher the score, the more favourable the view of nursing. Table 5.3 shows the mean scores for each statement across all the respondents and across the four fields of nursing. Statistically significant differences (p = <0.05) in responses were identified by Kruskal-Wallis H Test and one-way ANOVA for

statements 1, 4, 8, 15, 18 and 20. The Kruskal-Wallis H Test also identified a statistically significant difference for statement 12.

Table 5.3: Mean Likert scale scores for each statement (students)

Statement	All [SD]	Adult [SD]	Child [SD]	LD [SD]	MH [SD]	Kruskal-Wallis H Test	One-way ANOVA
1. Nurses are advocates for the patients/clients	4.55 [0.60]	4.40 [0.65]	4.84 [0.38]	4.71 [0.47]	4.64 [0.54]	$\chi^2(2) = 11.706$, $p = 0.008$	$F(3,145) = 3.947$, $p = 0.010$
2. Nurses protect patients/clients in the healthcare system	4.33 [0.63]	4.22 [0.62]	4.58 [0.61]	4.41 [0.62]	4.40 [0.65]	$\chi^2(2) = 6.574$, $p = 0.087$	$F(3,144) = 2.027$, $p = 0.113$
3. Nurses participate in the development of health policies	3.87 [0.78]	3.83 [0.79]	4.06 [0.54]	3.65 [1.00]	3.97 [0.74]	$\chi^2(2) = 1.907$, $p = 0.592$	$F(3,138) = 1.069$, $p = 0.364$
4. Nurses should wear a uniform in order to be identified	3.89 [1.20]	4.52 [0.77]	4.05 [1.03]	2.65 [1.22]	3.03 [1.08]	$\chi^2(2) = 56.418$, $p = 0.000$	$F(3,145) = 31.481$, $p = 0.000$
5. Nurses act as 'resource persons' for individuals with health problems	4.11 [0.68]	4.10 [0.64]	4.05 [0.52]	4.00 [0.79]	4.21 [0.78]	$\chi^2(2) = 2.310$, $p = 0.511$	$F(3,136) = 0.448$, $p = 0.719$
6. Nurses in general are kind, compassionate human beings	3.97 [0.81]	3.91 [0.79]	4.05 [0.71]	3.94 [1.20]	4.06 [0.73]	$\chi^2(2) = 1.091$, $p = 0.779$	$F(3,143) = 0.347$, $p = 0.791$
7. It takes intelligence to be a nurse	3.82 [0.92]	3.89 [0.84]	3.32 [0.89]	3.88 [1.27]	3.91 [0.85]	$\chi^2(2) = 7.700$, $p = 0.053$	$F(3,143) = 2.279$, $p = 0.082$
8. The service given by nurses is as important as that given by doctors	4.84 [0.46]	4.74 [0.59]	5.00 [0]	4.94 [0.24]	4.94 [0.24]	$\chi^2(2) = 9.488$, $p = 0.023$	$F(3,144) = 2.905$, $p = 0.037$
9. Everyone would benefit if nurses spent less time in the university and more time in clinical practice	3.41 [1.10]	3.41 [1.12]	3.53 [1.07]	3.24 [1.30]	3.44 [1.00]	$\chi^2(2) = 0.419$, $p = 0.936$	$F(3,143) = 0.222$, $p = 0.881$
10. Nurses integrate health teaching into their practice	3.99 [0.76]	3.99 [0.77]	4.00 [0.75]	3.76 [0.97]	4.09 [0.61]	$\chi^2(2) = 0.896$, $p = 0.826$	$F(3,144) = 0.687$, $p = 0.562$
11. Research is vital to nursing as a profession	3.73 [1.07]	3.55 [1.10]	3.67 [0.97]	4.19 [0.75]	3.94 [1.09]	$\chi^2(2) = 6.957$, $p = 0.073$	$F(3,142) = 2.249$, $p = 0.085$
12. Nurses should be politically active	2.97 [0.90]	3.03 [0.93]	2.47 [0.51]	3.00 [1.10]	3.13 [0.83]	$\chi^2(2) = 8.102$, $p = 0.044$	$F(3,133) = 2.427$, $p = 0.068$
13. Nurses are capable of independent practice	3.97 [0.84]	4.04 [0.86]	4.16 [0.60]	3.94 [0.83]	3.74 [0.89]	$\chi^2(2) = 4.282$, $p = 0.233$	$F(3,142) = 1.366$, $p = 0.256$
14. Nurses speak out about inadequate working conditions	3.20 [0.96]	3.07 [0.95]	3.35 [1.06]	3.65 [1.00]	3.17 [0.86]	$\chi^2(2) = 5.885$, $p = 0.117$	$F(3,138) = 1.896$, $p = 0.133$

15. Nurses are compensated sufficiently for their work by the knowledge that they are helping people	3.23 [0.99]	3.25 [1.02]	3.95 [0.71]	2.88 [0.89]	2.97 [0.94]	$\chi^2(2) = 14.867$, $p = 0.002$	$F(3,139) = 5.262$, $p = 0.002$
16. Nurses should have a right to strike	3.65 [1.00]	3.70 [0.96]	3.61 [0.98]	3.94 [1.06]	3.41 [1.04]	$\chi^2(2) = 4.338$, $p = 0.227$	$F(3,133) = 1.164$, $p = 0.326$
17. Nurses follow the doctor's orders without question	2.02 [0.85]	2.01 [0.81]	1.84 [0.77]	2.12 [0.78]	2.08 [1.00]	$\chi^2(2) = 1.003$, $p = 0.801$	$F(3,144) = 0.420$, $p = 0.739$
18. Men make good nurses	4.39 [0.70]	4.34 [0.61]	4.84 [0.38]	4.24 [0.66]	4.31 [0.82]	$\chi^2(2) = 11.722$, $p = 0.008$	$F(3,141) = 3.710$, $p = 0.013$
19. Many nurses who are seeking higher degrees would really rather be doctors	2.13 [0.82]	2.11 [0.71]	2.00 [0.69]	2.63 [1.31]	2.00 [0.73]	$\chi^2(2) = 3.157$, $p = 0.368$	$F(3,126) = 2.449$, $p = 0.067$
20. Nursing is exciting	4.43 [0.67]	4.29 [0.71]	4.74 [0.45]	4.24 [0.66]	4.64 [0.59]	$\chi^2(2) = 12.763$, $p = 0.005$	$F(3,143) = 4.252$, $p = 0.007$
21. Nurses incorporate research findings into their clinical practice	3.75 [0.88]	3.63 [0.84]	3.61 [0.98]	4.12 [0.60]	3.91 [1.01]	$\chi^2(2) = 7.143$, $p = 0.067$	$F(3,139) = 2.014$, $p = 0.115$
22. The major goal of nursing research is to improve patient care	4.37 [0.81]	4.42 [0.78]	4.21 [0.79]	4.65 [0.49]	4.24 [0.99]	$\chi^2(2) = 3.431$, $p = 0.330$	$F(3,140) = 1.320$, $p = 0.270$
23. Nurses are adequately paid for the work they do	2.17 [1.03]	2.14 [0.98]	2.21 [0.98]	1.76 [1.09]	2.43 [1.12]	$\chi^2(2) = 5.759$, $p = 0.124$	$F(3,140) = 1.659$, $p = 0.179$
24. Nurses value time at the bedside caring for patients/clients	4.28 [0.85]	4.25 [0.93]	4.33 [0.49]	4.12 [0.99]	4.40 [0.74]	$\chi^2(2) = 1.021$, $p = 0.796$	$F(3,142) = 0.495$, $p = 0.686$
25. Nurses should have a degree for entrance into practice	3.31 [1.16]	3.49 [1.17]	2.68 [1.20]	3.41 [1.06]	3.28 [1.11]	$\chi^2(2) = 6.849$, $p = 0.077$	$F(3,136) = 2.475$, $p = 0.064$
26. Nurses with higher degrees make important contributions to patient/client care	3.26 [1.01]	3.22 [0.91]	2.95 [0.97]	3.47 [1.13]	3.40 [1.17]	$\chi^2(2) = 3.932$, $p = 0.269$	$F(3,136) = 1.113$, $p = 0.346$
27. Nursing is a respected profession	3.88 [0.95]	3.89 [0.99]	4.00 [0.67]	3.71 [1.16]	3.86 [0.90]	$\chi^2(2) = 0.539$, $p = 0.910$	$F(3,144) = 0.300$, $p = 0.826$
28. Nurses consistently update their practice in relation to current health trends	3.75 [0.91]	3.66 [0.93]	3.94 [0.94]	4.00 [0.94]	3.71 [0.86]	$\chi^2(2) = 3.189$, $p = 0.363$	$F(3,143) = 0.950$, $p = 0.418$
29. Nurses feel good about what they do	4.05 [0.80]	3.96 [0.87]	4.47 [0.51]	4.12 [0.70]	3.97 [0.77]	$\chi^2(2) = 6.652$, $p = 0.084$	$F(3,142) = 2.309$, $p = 0.079$

Table 5.4 shows the Tukey HSD and Bonferroni Corrections for those statements where a statistically significant difference was identified using one-way ANOVA.

Table 5.4: Tukey HSD and Bonferroni Corrections for relevant statements

Statement	Tukey HSD	Bonferroni Correction
1. Nurses are advocates for the patients/clients	Adult & Child: $p = 0.017$	$p = 0.020$
4. Nurses should wear a uniform in order to be identified	Adult & Learning Disabilities: $p = 0.001$ Adult & Mental Health: $p = 0.001$ Child and Learning Disabilities: $p = 0.001$ Child & Mental Health: $p = 0.001$	$p = 0.001$ $p = 0.001$ $p = 0.001$ $p = 0.001$
8. The service given by nurses is as important as that given by doctors	No statistical difference identified	
15. Nurses are compensated sufficiently for their work by the knowledge that they are helping people	Adult & Child: $p = 0.026$ Child and Learning Disabilities: $p = 0.006$ Child and Mental Health: $p = 0.002$	$p = 0.030$ $p = 0.007$ $p = 0.002$
18. Men make good nurses	Adult & Child: $p = 0.018$ Child and Learning Disabilities: $p = 0.030$ Child and Mental Health: $p = 0.022$	$p = 0.020$ $p = 0.036$ $p = 0.025$
20. Nursing is exciting	Adult & Child: $p = 0.044$ Adult & Mental Health: $p = 0.048$	$p = 0.053$ $p = 0.059$

Although not in the 'statistical' sense, the responses to 'statement 25', 'Nurses should have a degree for entrance into practice' are significant. An overall mean score of 3.31 suggested that participants were largely 'neutral' about the need for nurses to require a degree. Indeed, the mean score across the child field students was 2.68, a slight leaning towards disagreeing with this statement. As with many such questionnaires, participants were not permitted opportunity to comment further on their responses to individual questions, therefore their rationale behind these responses was not explored. 'Statement 7', 'It takes intelligence to be a nurse' scored a higher overall mean score (3.82, SD: 0.92) and mean scores across each field than the statement regarding degree status. Intelligence and graduate status are not mutually inclusive, but it is worth noting the participants' higher scores for the former compared with the later. There was leaning towards 'disagree' with 'statement 19', that many nurses seeking higher degrees would rather be doctors (Mean: 2.13, SD: 0.82). Respondents could not speak on behalf of these 'many nurses' but their responses

perhaps suggest that these participants recognised a value to nursing of improved academic status. The responses to 'statement 26' suggest that the participants were largely 'neutral' (Mean: 3.26, SD: 1.01) on the impact that nurses with higher degrees had on improvements to patient/service user care. Nursing as a profession needs to examine ways of investigating the impact of graduate status on patient/service user care, beyond the influence that has been shown regarding reduced mortality (Aiken *et al.*, 2003; Aiken *et* al, 2014; Gkantaras, *et al.* 2016). The responses to 'statement 11', 'Research is vital to nursing as a profession' produced a mean score of 3.73 (SD: 1.07) (leaning towards 'agree'). The wording of this statement highlights a crucial role of research *in* nursing for the development *of* nursing. However, when this is compared with 'statement 22', 'The major goal of nursing research is to improve patient care' (Mean: 4.37, SD: 0.81), there is a recognition that research in nursing should primarily be aimed at improving patient care.

There was strong agreement that nurses were advocates for patients ('statement 1', Mean: 4.55, SD: 0.60), protecting them ('statement 2', Mean: 4.33, SD: 0.63) and acting as a resource ('statement 5', Mean: 4.11, SD: 0.68) with the service given by nurses deemed to be as important as that given by doctors ('statement 8', Mean: 4.84, SD: 0.46). Nurses do not simply follow doctors' orders without question ('statement 17', Mean: 2.02, SD: 0.85), and are capable of independent practice ('statement 13', Mean: 3.97, SD: 0.84). Nurses are also, in general, kind, compassionate human beings ('statement 6', Mean: 3.97, SD: 0.81) and value time spent at the bedside ('statement 24', Mean: 4.28, SD:0.85).

5.3 Quantitative data: Nurse educator questionnaire

The questionnaire was completed by twenty nurse educators representing the four fields of nursing. Table 5.5 shows the number of respondents per field of nursing, their gender, and average number of years spent in clinical practice and academia.

Table 5.5: Demographic details for nurse educator respondents

	Field of nursing				
	Adult	**Child**	**Learning Disability**	**Mental Health**	**All**
Number [percentage of total]	12 [60]	2 [10]	3 [15]	3 [15]	20 [100]
Gender Female Male	 5 7	 2 0	 2 1	 1 2	 10 10
Mean years worked in clinical practice [SD]	15.50 [6.17]	22.50 [3.53]	18.00 [8.18]	11.83 [7.42]	16.02 [6.60]
Mean years worked in academia [SD]	11.92 [6.14]	7.00 [1.41]	12.00 [4.00]	14.00 [6.00]	11.75 [5.53]

Cronbach alpha scores were calculated on categories of statements and are shown in Table 5.6. Category One included statements that took a generally positive stance to the move to an all graduate entry and Category Two a more negative view. 'Statement 2' was categorised as 'positive' but all twenty respondents 'strongly agreed' (five points) with this statement and therefore it had zero variance and was removed from the Cronbach alpha calculations. 'Statement 4' was deemed to be neutral and considered as a statement on its own, therefore not appropriate for a Cronbach alpha calculation.

Table 5.6: Cronbach alpha scores for nurse educator questionnaire

Category	Statements included	Cronbach alpha score
One (Positive view)	1, 3, 8, 10, 13, 16, 19, 20	.73
Two (Negative view)	5, 6, 7, 9, 11, 12, 14, 15, 17, 18	.61

Table 5.7 shows the mean scores for each statement across all the respondents and per field of nursing. Due to the low number of respondents, statistical significances between the fields of nursing were not calculated.

Table 5.7: Mean Likert scale scores for each statement (nurse educators)

Statement	All [SD]	Adult [SD]	Child [SD]	LD [SD]	MH [SD]
1. The move to all graduate entry for nursing is a necessity to deliver healthcare in the 21st century	4.70 [0.73]	4.92 [0.29]	4.50 [0.71]	5.00 [0]	3.67 [1.53]
2. Nursing is a profession that requires highly knowledgeable and competent individuals	5.00 [0]	5.00 [0]	5.00 [0]	5.00 [0]	5.00 [0]
3. Nurses, like colleagues in Occupational Therapy, Physiotherapy and Radiography should be educated to degree level	4.75 [0.44]	4.75 [0.45]	4.50 [0.71]	5.00 [0]	4.67 [0.58]
4. Nursing is a vocation	3.58 [1.02]	3.18 [1.08]	4.50 [0.71]	4.00 [1.00]	4.00 [0]
5. A short term technical training is all that is required to become a Registered Nurse	1.10 [0.31]	1.08 [0.29]	1.00 [0]	1.00 [0]	1.33 [0.58]
6. Nursing has lost sight of its true aims	2.50 [1.00]	2.42 [1.00]	2.00 [0]	2.67 [1.53]	3.00 [1.00]
7. All graduate entry will exclude some excellent candidates, who would make great nurses, from entering the profession	2.47 [1.17]	2.58 [1.31]	2.00 [NA]	1.67 [0.58]	3.00 [1.00]
8. Nursing needs individuals who have the skills and knowledge to undertake high levels of clinical decision making	4.75 [0.91]	4.67 [1.16]	5.00 [0]	5.00 [0]	4.67 [0.58]
9. An all graduate entry into nursing is not going to encourage more people into the profession	2.75 [1.07]	2.75 [1.14]	2.50 [0.71]	2.67 [1.53]	3.00 [1.00]
10. Academic achievement and safe, compassionate care are not mutually exclusive	4.50 [0.51]	4.50 [0.52]	4.00 [0]	4.67 [0.58]	4.67 [0.58]
11. The only thing that having a degree will do is widen the gap between those people doing the actual nursing on the wards (i.e. the health care support staff) and the 'qualified' nurses	2.05 [1.15]	2.08 [1.08]	1.50 [0.71]	1.33 [0.58]	3.00 [1.73]
12. Nurses should be judged on their ability to do the job and not on their academic achievements	2.80 [1.36]	2.83 [1.34]	1.50 [0.71]	3.33 [1.53]	3.00 [1.73]
13. Nursing as a profession cannot develop and evolve without degree level education	4.20 [1.15]	4.17 [1.19]	4.50 [1.41]	4.33 [1.16]	4.00 [1.73]
14. A degree cannot enable a nurse to be compassionate to a patient	3.35 [1.31]	3.50 [1.17]	3.00 [0]	3.33 [2.08]	3.00 [1.73]
15. Degrees will take nurses even further away from the bedside	1.90 [0.91]	1.75 [0.62]	2.00 [0.71]	2.67 [2.08]	1.67 [0.58]
16. Greater academic knowledge will help nurses care for their patients at a higher level	4.65 [0.59]	4.58 [0.67]	4.50 [0.71]	5.00 [0]	4.67 [0.58]
17. The degree should only be made mandatory after completing the diploma programme and gaining some post-qualification experience	2.00 [1.03]	2.00 [1.04]	2.00 [0]	2.00 [1.73]	2.00 [1.00]
18. An all graduate entry will exclude many mature students who would make excellent nurses	2.28 [1.02]	2.09 [0.94]	2.00 [NA]	2.33 [1.53]	3.00 [1.00]
19. Nursing is not simply the carrying out of uncomplicated tasks under the direction of others	4.89 [0.32]	4.92 [0.29]	5.00 [0]	5.00 [0]	4.67 [0.58]
20. Moving to an all graduate entry is the best thing to ever happen to Nursing	3.50 [1.00]	3.58 [1.08]	3.50 [0.71]	4.00 [1.00]	2.67 [0.58]

Table 5.8 shows the mean scores for Category One (positive view) and Category Two (negative view) statements. The higher the score for Category One and the lower the score for Category Two, the more favourable the view of the move to an all graduate entry. The tables also include a mean score for these groups across each field of nursing.

Table 5.8: Mean Likert scale scores for Category One and Category Two statements (nurse educators)

Category	All [SD]	Adult [SD]	Child [SD]	LD [SD]	MH [SD]
One (Positive view	4.49 [0.45]	4.51 [0.45]	4.44 [0.50]	4.75 [0.39]	4.21 [0.73]
Two (Negative view)	2.32 [0.61]	2.31 [0.67]	1.95 [0.55]	2.30 [0.79]	2.60 [0.66]

Despite some variation for each statement across the four fields of nursing, respondents were generally positive about the move to an all graduate entry although respondents were more 'neutral' regarding the statement that the move was the best thing to ever happen to nursing ('statement 20').

'Statement 4', 'Nursing is a vocation' produced a mean score across the four fields of 3.58 (neutral to agree) with the mean scores for each field of Adult 3.18; Child 4.50; LD 4.00; MH 4.00. Nurse educators from the child field agreed more strongly that nursing was a vocation than the other fields. Adult field educators were, on average, neutral about this.

5.4 Quantitative data: AHP educator questionnaire

The questionnaire was completed by fifteen AHP educators. Table 5.9 provides some demographic details for these participants.

Table 5.9: Demographic details for AHP educators

	Health Profession					
	Midwifery (Mid)	Occupational Therapy (OT)	Operating Department Practice (ODP)	Physiotherapy (Physio)	Podiatry (Pod)	All
Number [percentage of total]	3 [20]	4 [27]	2 [13]	3 [20]	3 {20}	15 [100]
Gender Female Male	 3 0	 4 0	 0 2	 3 0	 1 2	 11 4
Mean years worked in clinical practice [SD]	13.00 [8.19]	18.25 [6.24]	9.00 [2.83]	11.00 [9.90]	8.00 [NA]	6.00 [5.20]
Mean years worked in academia [SD]	15.16 [10.61]	6.25 [0.96]	20.50 [13.43]	14.50 [6.36]	13.33 [6.95]	11.32 [8.43]

As with the nurse educator questionnaire, Cronbach alpha scores (Table 5.10) were calculated on categories of statements. There was variance in the responses to 'statement 2' amongst these participants therefore it was included in Category One. 'Statement 4' was, once again, deemed to be neutral, therefore considered as a statement on its own and not appropriate for a Cronbach alpha calculation.

Table 5.10: Cronbach alpha scores for AHP educator questionnaire

Category	Statements included	Cronbach alpha score
One (Positive view)	1, 2, 3, 8, 10, 13, 16, 19, 20	.86
Two (Negative view)	5, 6, 7, 9, 11, 12, 14, 15, 17, 18	.87

Table 5.11 shows the mean scores for each statement across all the respondents and each allied health profession. Due to the low number of respondents, statistical significances between the fields of nursing were not calculated.

Table 5.11: Mean Likert scale scores for each statement (AHP educators)

Statement	All [SD]	Mid [SD]	OT [SD]	ODP [SD]	Physio [SD]	Pod [SD]
1. The move to all graduate entry for nursing is a necessity to deliver healthcare in the 21st century	3.60 [1.45]	3.67 [1.53]	4.50 [1.00]	4.00 [1.41]	4.00 [1.00]	1.67 [1.56]
2. Nursing is a profession that requires highly knowledgeable and competent individuals	4.50 [0.94]	5.00 [0]	4.75 [0.50]	4.00 [1.41]	4.67 [0.58]	3.50 [2.12]
3. Nurses, like colleagues in Occupational Therapy, Physiotherapy and Radiography should be educated to degree level	3.67 [1.50]	3.67 [1.53]	4.75 [0.50]	3.50 [2.12]	4.00 [1.00]	2.00 [1.73]
4. Nursing is a vocation	3.62 [1.26]	3.33 [1.53]	4.25 [1.50]	3.00 [1.41]	3.00 [0]	5.00 [NA]
5. A short term technical training is all that is required to become a Registered Nurse	1.69 [0.95]	1.33 [0.58]	1.00 [0]	2.00 [1.41]	2.00 [0]	4.00 [NA]
6. Nursing has lost sight of its true aims	3.15 [1.35]	4.00 [0]	2.25 [1.89]	4.00 [0]	2.67 [1.16]	4.00 [0]
7. All graduate entry will exclude some excellent candidates, who would make great nurses, from entering the profession	3.47 [1.46]	2.67 [1.16]	3.00 [1.83]	2.50 [2.12]	4.00 [0]	5.00 [0]
8. Nursing needs individuals who have the skills and knowledge to undertake high levels of clinical decision making	4.64 [0.63]	4.67 [0.58]	5.00 [0]	4.00 [1.41]	4.67 [0.58]	4.50 [0.71]
9. An all graduate entry into nursing is not going to encourage more people into the profession	2.67 [1.44]	3.33 [1.16]	2.00 [1.73]	2.50 [2.12]	3.33 [1.16]	1.00 [NA]
10. Academic achievement and safe, compassionate care are not mutually exclusive	3.93 [1.21]	4.33 [0.58]	3.50 [1.73]	3.50 [0.71]	4.00 [1.73]	4.50 [0.71]
11. The only thing that having a degree will do is widen the gap between those people doing the actual nursing on the wards (i.e. the health care support staff) and the 'qualified' nurses	1.82 [1.17]	2.33 [1.53]	1.25 [0.50]	1.00 [NA]	3.00 [1.41]	1.00 [NA]
12. Nurses should be judged on their ability to do the job and not on their academic achievements	2.40 [1.18]	2.33 [0.58]	2.00 [1.41]	2.50 [2.12]	2.00 [0]	3.33 [1.53]
13. Nursing as a profession cannot develop and evolve without degree level education	4.00 [1.46]	4.33 [0.58]	4.75 [0.50]	3.50 [2.12]	4.67 [0.58]	2.33 [2.31]
14. A degree cannot enable a nurse to be compassionate to a patient	4.00 [1.25]	3.67 [1.53]	4.75 [0.50]	2.50 [0.71]	4.00 [1.73]	4.33 [1.16]
15. Degrees will take nurses even further away from the bedside	2.00 [1.13]	2.33 [1.53]	2.00 [1.41]	1.00 [NA]	2.33 [0.58]	1.00 [NA]
16. Greater academic knowledge will help nurses care for their patients at a higher level	4.13 [0.83]	4.33 [0.58]	4.75 [0.50]	4.50 [0.71]	4.00 [0]	3.00 [1.00]
17. The degree should only be made mandatory after completing the diploma programme and gaining some post-qualification experience	2.17 [1.59]	2.67 [2.08]	1.25 [0.50]	1.00 [NA]	2.33 [1.53]	5.00 [NA]

18. An all graduate entry will exclude many mature students who would make excellent nurses	2.60 [1.55]	2.33 [1.53]	1.75 [1.50]	2.50 [2.12]	3.33 [1.56]	3.33 [2.08]
19. Nursing is not simply the carrying out of uncomplicated tasks under the direction of others	4.60 [0.63]	4.67 [0.58]	5.00 [0]	4.00 [1.41]	4.33 [0.58]	4.67 [0.58]
20. Moving to an all graduate entry is the best thing to ever happen to Nursing	3.07 [1.44]	2.67 [1.52]	4.00 [1.41]	3.50 [2.12]	3.33 [0.58]	1.67 [1.16]

Table 5.12 shows these scores for Category One (positive view) and Category Two (negative view) statements. The higher the score for Category One and the lower the score for Category Two, the more favourable the view of the move to an all graduate entry.

Table 5.12: Mean Likert scale scores for Category One and Category Two statements (AHP educators)

Category	All [SD]	Mid [SD]	OT [SD]	ODP [SD]	Physio [SD]	Pod [SD]
One (Positive view)	3.92 [0.50]	4.00 [0.64]	4.53 [0.49]	3.83 [0.35]	4.11 [0.41]	2.89 [1.32]
Two (Negative view)	2.60 [0.75]	2.70 [0.78]	2.12 [1.09]	2.15 [0.94]	2.90 [0.75]	3.20 [1.62]

Although the sample was small, a key outcome was the mean scores obtained from educators in podiatry compared with the other professions. The score for Category One statements was lower and for Category Two statement higher for podiatry staff when compared to the other health professions, indicating that they were, as a group, less favourable about the move to an all graduate entry to nursing. These outcomes reflect the concerns expressed by participants from podiatry who provided free text data presented in section 5.10.3 below.

Table 5.13 highlights the mean scores for Category One and Two statements for nursing and the AHPs. As before, the higher the score for Category One and the lower the score for Category Two, the more favourable the view of the move to an all graduate entry. Educators in nursing were more in favour of the move to an all graduate entry than AHP colleagues. This was especially noticeable if the scores for podiatry were included in the AHP totals.

Table 5.13: Comparison of mean Likert Scale scores across nursing and AHP educators

Category	Nursing [SD]	AHP including Podiatry [SD]	AHP excluding Podiatry [SD]
One (Positive view)	4.49 [0.45]	3.92 [0.50]	4.12 [0.38]
Two (Negative view)	2.32 [0.61]	2.60 [0.75]	2.47 [0.71]

5.5 Qualitative data: Student focus group meetings

Four students, one representing each field of nursing consented to participate in the focus group which met on four separate occasions over the first two years of the programme.

The meetings were held:

1. At the end of the initial theory block for year one.
2. Following the students' first clinical placement in year one.
3. At the start of year two, following their second clinical placement in year one.
4. Following their third clinical placement and towards the end of the main theory block for year two.

To protect their anonymity, the students will be referred to throughout as S1 to S4 and their field of nursing will not be presented unless discussed specifically by themselves. The rationale for this is linked with reducing any possibility of participants being identified by virtue of their field.

5.5.1 Phase one analysis

First meeting

Figure 5.1 highlights the questions that were asked at this first meeting following a framework suggested by Kruger and Casey (2000).

My initial impression following transcription was that this was quite a negative portrayal. However, on further review the account was a critique of their experiences on the programme to that point, and did give a positive view as well as areas of frustration and concern. The critique extended to staff they had worked with in clinical practice. It is worth noting that at this stage the students had only spent two 'taster' days in their clinical placements. Despite this short period of time, the students felt able to offer some critique of what they had seen, commenting especially on the level of paperwork completed by and a lack of 'caring' from some Registered Nurses (RNs). Their fear of becoming 'normalised' was apparent as were their accusations of an 'ideal' being taught in university with little reflection regarding the 'real' they saw demonstrated in clinical practice.

Student focus group (first meeting) – End of initial theory block

Opening question (Quick and easy to answer – not usually analysed)

1. Please tell us your name and which field of nursing you are studying.

Introductory question (Introduce the topic and get the participants to start thinking about the issues)

2. How do you feel you have settled into the course so far?

Transition questions (Move the conversation towards the key questions)

3. What were your experiences of the admissions process?
4. How did you find induction/fresher's week?

Key questions

5. Tell me about your experiences of the lectures/theory sessions you have had so far.
6. What about the time in the simulation suite?
7. Have you met with your personal tutor?
8. You spent two days in your placement area last week. Tell me how these went.
9. Did you meet your mentor?
10. What are your expectations for the rest of your time on your placement area?

Ending question (Bring closure to the discussions and enable participants to reflect on previous comments)

11. We have discussed your experiences on the course so far. Before we finish is there anything I have missed or anything you would like to add?

Other follow on questions will be linked to the answers obtained all focused on the students' experiences on the course so far.

Figure 5.1: Question guide for student focus group (first meeting)

Second meeting

This focus group meeting was attended by three of the four participants; S1 was unable to attend at very short notice due to family illness. It was designed to review the students' experiences on their first nine-week placement. Figure 5.2 contains the question guide for this meeting. It was clear that there had been a range of opportunities to implement the 'fundamental skills' they had studied prior to the placement. There were differences across the fields, but this also reflected the different placement areas. All of the students stated that they had not spent the required 40% of the time working with their mentor (although this was not

independently verified), and actively sought opportunities to work with others who they felt more comfortable with.

Student focus group (second meeting)

Opening question

1. Please remind us of your name and which field of nursing you are studying and describe briefly the clinical environment that you have been working in during your first placement. Please do not mention the name of the area itself, but give a broad overview of the type of work done there.

Introductory question

2. What sort of work did you do?

Transition questions

3. How often did you work with your mentor?
4. How would you define the purpose of you being there? Learner first, care-giver second? Care-giver first, learner second? A balance? Etc.

Key questions

5. How do you think the staff there (including your mentor) perceived the purpose for you being there?
6. Having worked alongside Registered Nurses from your field of nursing now, how would you define the role of the Registered Nurse from your particular field?
7. Were you given the opportunity to practice some of the essential clinical skills taught in the simulation suite?
8. Was the fact that you were a degree student mentioned at all?
9. If so, how did this affect your experience?
10. Did you feel part of the healthcare team?
11. Have your experiences on this placement changed your view of the profession? If so, how?

Ending question

12. We have discussed your experiences on the course so far. Before we finish is there anything I have missed or anything you would like to add?

Other follow on questions will be linked to the answers obtained all focused on the students' experiences on the course so far.

Figure 5.2: Question guide for student focus group (second meeting)

There were some discussions about feeling accepted onto the ward/department and a recognition that they needed to feel comfortable in the environment before any meaningful learning could begin. This first placement was clearly a time of anxiety and stress to some. They all felt that they needed to be a little more assertive in future placements, striving to carve out learning opportunities available to them as a student rather than just be counted amongst the 'carers'.

There was further critique of the standards of care they witnessed, especially from the RNs who were accused of not advocating for the patients/service users (S4) and not caring (S2), though differences were noted between those RNs who had recently qualified and those that had been qualified for several years. The students did note that a negative experience could lead to positive learning.

Third meeting

This focus group meeting was held at the start of the students' second year. They were towards the end of two weeks of theory in university before undertaking another placement (hub and spoke). Figure 5.3 contains the question guide for this meeting.

The purpose of this meeting was to discuss their experiences on the programme since the last meeting, concentrating on their second placement and the two weeks of theory that they were just completing. The students had had a variety of different placements, with one returning to the same hub as before. The advantages and disadvantages of this were discussed. What came across very clearly was that the students needed to be proactive in organising who they worked with as all expressed issues with spending sufficient time with their mentor. They tried to find someone to work with who looked interested in having a student or was good at explaining things. They also needed to be proactive regarding which shifts they worked, especially if there was more than one other student on the placement. The length of each placement was also discussed, with a generally supportive view of the hub and spoke model, although some frustrations were expressed around the timings of the spokes.

Student focus group (third meeting)

Opening question

1. Please remind us of your name and which field of nursing you are studying and describe briefly the clinical environment that you have been working in during your last placement. Tell me about your hub and the spoke(s) that you attended as well. Please do not mention the name of the area itself, but give a broad overview of the type of work done there.

Introductory question

2. Please give a brief overview of the work you did during your last placement, including what you did on your spoke.

Transition questions

3. Did you have a designated mentor assigned to you as soon as you arrived?
4. How often did you work with your mentor?
5. Who else did you work alongside?

Key questions

6. I'm interested in your integration to the healthcare team. Some of you went back to the same placement whilst others of you were somewhere new. How do you think this changed things?
7. Were there any other students there from other years on the course and if so, how did you find working alongside these?
8. Was the fact that you were a degree student a factor?
9. What would you say you have learnt as a result of undertaking your last placement?
10. Have your experiences on this placement changed your view of the profession? If so, how?

Ending question

11. We have discussed your experiences on the course so far. Before we finish is there anything I have missed or anything you would like to add?

Other follow on questions will be linked to the answers obtained all focused on the students' experiences on the course so far.

Figure 5.3: Question guide for student focus group (third meeting)

It was clear that each student had benefitted from their last placement and all reflected on what they had learnt. S3 stated that she felt unprepared for practice and would have liked more time in the simulation suite. There were strong feelings across the group that theory sessions needed to be more interactive. The students had had a variety of experiences but it was clear that they were still enthusiastic about nursing, still had at their core the reasons why they wanted to be a nurse, and were determined to be the best nurse that they could be. There was certainly no hint that their experiences had knocked them off course.

Fourth meeting

This meeting (the guide can be found in Figure 5.4) was held around two-thirds of the way through the second year, towards the end of the main theory block. The students had had a ten-week placement at the start of year two so were reflecting on this and the theory block they had had since returning from placement. There was universal acceptance that, as far as clinical practice was concerned, their confidence had improved further. Not only had their 'clinical confidence' improved but they felt more confident in communicating with mentors and other staff, and carving out learning opportunities.

Student focus group (fourth meeting)

These focus groups are not group interviews as such as I am interested in utilising the interaction between the students as the group explores their different experiences. The questions will be guided to some extent by the issues raised, but will address areas such as:

Opening question

1. Please remind us of your name and which field of nursing you are studying

Introductory question

2. Please give a brief overview of your experiences so far in your second year.

Transition questions (Move the conversation towards the key questions)

3. Let's think specifically about your placement at the beginning of the year. I have asked this question before about previous placements, but would you summarise what you feel you learnt on this placement?
4. Same question but focused on the theory blocks.
    a. Timing
    b. Content
    c. Delivery
    d. IPL
    e. Research

Key questions

5. Have these experiences changed your view of nursing and the role of the qualified nurse? Give details.
6. From your own experiences, how would you describe both the role of the student nurse and how the student nurse is viewed by
    a. Health care assistants
    b. Registered Nurses
    c. Other Allied Health Professionals
    d. Doctors

Ending question

7. We have discussed your experiences on the course so far. Before we finish is there anything I have missed or anything you would like to add?

Figure 5.4: Question guide for student focus group (fourth meeting)

There were differences in the length of these placements with one student not having a spoke therefore spending all ten weeks in the same area and another having two spokes and not spending more than four weeks in any one area.

As before, there were variations in the standards of mentorship, although some were keen to defend their mentors. Once again, across the fields they critiqued the standards of nursing care and compassion that they had seen. Overall the group members felt that the academic work in year two had been more relevant than year one. They stated again that they felt unprepared for their first placement; that there had been too many generic concepts. There were also discussions on whether/how the University was preparing them for and shaping their nursing role.

5.5.2 Development of codes and themes: Student focus group

For phase two of Braun and Clarke's (2006) approach, each meeting was coded in turn. The initial codes from the first meeting were carried over to the second meeting and further codes were added as required. The same process was undertaken for the third and fourth meetings. Table 5.14 summarises the codes devised for the first meeting and the additional ones for each subsequent meeting. There were no new codes added during analysis of the fourth meeting. Table 5.15 summarises the distribution of these initial codes across the four meetings.

Table 5.14: Initial codes devised during analysis of the student focus group meetings

Student Focus Group (First meeting)	Student Focus Group (Second meeting)	Student Focus Group (Third meeting)
Academic Support - Role of personal tutor	Advocate	Bitching
Active learning	Agency staff	Increased confidence
Apprentice-style training	An annoying addition	Pre-course care experience
Box-ticking	Be approved of	What did I do and learn on placement?
Changes to timetable	Care (a desire/motivation to care)	
Clearer direction	Changing view of nursing	
Course organisation	Develop a resilience	
Covering your back	Generational differences	
Critique of practice	Health Care assistants	
Degree/graduate status	I cried	
Evaluation of course	Inspired	
Expectation of others	Need to be more assertive	
Feeling underprepared	Part of the team	
Field identity	Role of Registered Nurse	
Group sizes		
I'm worried about becoming one of them		
Ideal v real		
Information overload		
Interaction with lecturers		
Inter-professional working		
Lack of confidence		
Learning environment – practice		
Lectures		
Mentor		
Paperwork		
Personal reading and study		
Placement		
Putting what you have learnt into practice		
Reflection		
Role of student		
Seminars		
Simulation and skills session		
Standards of care		
Student v carer		
Working with other students		

Table 5.15: Distribution of initial codes across the four student focus group meetings

	Focus Group Meeting			
Code	First	Second	Third	Fourth
Academic Support	■			
Active learning	■			
Advocate		■		■
Agency staff		■		
An annoying addition		■		
Apprentice-style training	■			
Be approved of		■		
Bitching			■	
Box-ticking	■		■	
Care (a desire/motivation to care)		■		
Changes to timetable	■			
Changing view of nursing		■	■	■
Clearer direction	■			
Course organisation	■			
Covering your back	■			
Critique of practice	■	■	■	■
Degree/graduate status	■	■	■	
Develop a resilience		■		
Evaluation of course	■		■	■
Expectation of others	■			
Feeling underprepared	■	■	■	■
Field identity	■		■	■
Generational differences		■	■	
Group sizes	■			
Health Care assistants		■	■	■
I cried		■		
I'm worried about becoming one of them	■	■	■	■
Ideal v real	■	■		
Increased confidence			■	■
Information overload	■			
Inspired		■		
Interaction with lecturers	■			
Inter-professional working	■	■	■	■
Lack of confidence	■			
Learning environment – practice	■	■		
Lectures	■		■	■
Mentor	■	■	■	■
Need to be more assertive		■	■	■
Paperwork	■		■	■
Part of the team		■	■	
Personal reading and study	■			
Placement	■	■	■	■
Pre-course care experience			■	
Putting what you have learnt into practice	■	■	■	
Reflection	■			
Role of personal tutor	■			■
Role of Registered Nurse		■	■	■
Role of student	■	■	■	■
Seminars	■		■	
Simulation and skills session	■	■	■	
Standards of care	■	■		■
Student v carer	■	■		
What did I do and learn on placement?			■	■
Working with other students	■	■	■	■

During phase three the codes were arranged under parent headings (Figure 5.5) which were considered as initial themes.

- Academic support
  - Personal Tutor
- Changing view of nursing
- Critique of practice
  - Box-ticking
  - Health care assistant
  - I'm worried about becoming one of them
  - Role of Registered Nurse
  - Standards of care
- Degree/graduate status
  - Apprentice-style training
- Evaluation of course
  - Active learning
  - Changes to timetable
  - Course organisation
  - Group sizes
  - 'Ideal' v 'real'
  - Lectures
    - Interaction with lecturers
    - Information overload
  - Personal reading and study
  - Seminars
  - Simulation and skills sessions
- Inter-professional working
- Miscellaneous
  - Pre-course care experience
  - Reflection
- Placement
  - Advocate
  - Agency staff
  - An annoying addition
  - Be approved of
  - Bitching
  - Covering your back
  - Developing a resilience
  - Expectation of others
  - Feeling underprepared
    - Increased confidence
    - Lack of confidence
  - Generational differences
  - Health care assistants
  - I cried
  - Inspired
  - Learning environment – practice
  - Mentor
  - Need to be more assertive or proactive
  - Paperwork
  - Part of the team
  - Putting what you have learnt into practice
  - What did I do and learn on placement?
  - Working with other students
- Role of student
  - Care
  - Student v carer

Figure 5.5: Phase three organisation of codes

Phases four and five generated the themes and sub-themes shown in Figure 5.6. The figures in brackets indicate the number of sources and the number of references for each theme or sub-theme.

Changing view of nursing (3/20)

Critique of practice
- Box-ticking (1/2)
- Health care assistants (3/14)
- I'm worried about becoming one of them (4/10)
- Level of care (4/28)
- Role of the Registered Nurse (3/23)

Degree/graduate status (3/14)

Inter-professional working (4/20)

Placement
- Advocate (2/6)
- Agency staff (1/3)
- An annoying addition (1/3)
- Be approved of (1/1)
- Bitching (1/1)
- Develop a resilience (1/1)
- Expectations of others (3/10)
- Feeling underprepared
- Increased confidence (2/9)
- Lack of confidence (3/9)
- Health care assistants (3/10)
- I cried (3/4)
- Learning environment – practice (4/15)
- Mentor (4/29)
- Need to be more assertive or proactive (3/3)
- Paperwork (3/8)
- Part of the team (2/13)
- Role of the student (4/20)
- What did I learn on placement? (4/28)
- Working with other students (4/9)

Pre-course care experience (2/2)

University – Theory
- Academic support (1/9)
  - Personal tutor (2/13)
- Emotional connection to learning
  - Active learning (3/6)
  - Field identity (3/10)
  - Group sizes (1/2)
  - Reflection (2/3)
  - Seminars (2/3)
  - Simulation and skills sessions (2/8)
- Evaluation (3/26)
- 'Ideal' v 'real' (2/3)
- Lectures
  - Information overload (1/3)
  - Interaction with lecturers and others (2/9)

Figure 5.6: Phases four and five: Themes and sub-themes

5.5.3 Further details of themes

The themes are presented in alphabetical order and are not ranked in order of number of occurrences across the focus group meetings.

Changing view of nursing

This theme centred on if/how the students' view of nursing changed as a result of their experiences on the programme. During the second meeting, S4 acknowledged that her view of nursing had changed, not least because her view of the role of the RN had changed. However, S4 did acknowledge that,

> I suppose, in the end of it, one placement for nine weeks isn't actually that much to realise what the whole of your profession is actually doing.

S3 acknowledged that she had been inspired through working with a particular group of Specialist Nurses and this had helped widen her view of nursing. S3 also commented that,

> I expected the hospital environment to be more erm, receptive and gentler [laughs] and that could be … I think I had had an ideal maybe, a kinder place to be.

A consistent element across all the meetings was a critique of practice and how this affected their view of nursing. S2 stated,

> There's this stigma attached to mental illness, but the way that I saw it before I went on placement was that was from people who didn't really understand it, and not from the professionals that actually worked in it … I just didn't like that environment and I just felt it like it wasn't like what we had been told that it would be, like this individualised care and this erm tailor made, and you work around the patient. I didn't see any of that.

It was also clear that following successive placements the students benefited from further experiences and a widening of their understanding of nursing. As S4 stated during the third meeting,

> It is not just about that person. It's the wider picture and I think I've only just realised how wide that picture can be. It's not just the families. It's not just the services, it's society as well and all those sorts of things and I don't think I realised the scope of what I could do within the role of learning disability nurse.

Finally, S3 offered an interesting perspective on the influences that had changed her view of nursing. During the fourth meeting she stated that,

> I think mine has developed and changed through the, through the academic stuff more than the placement this time. Erm, coz I've always thought I want to do district nursing, but I think the more we've done in acute care and the more I've been studying anatomy and physiology the more excited I've got by that.

S3's perspective here offers some insight into the influences of the theoretical elements of the course as well as the time spent in clinical practice. It highlights the important role that academic staff undertake in being passionate and enthusiastic about nursing in general and more specialist areas of nursing in particular.

Critique of practice

This theme contained a number of sub-themes and centred on the students offering a passionate critique of the standards of care they had observed. There were accusations that on occasions patient assessments were undertaken as a, "tick-box exercise," (S2) with the same student stating how they were later challenged by RNs for taking too long to complete an assessment,

> You're kind of knocked down, like you're inefficient for spending that long doing it. It's kind of seen as a task.

There was unanimous agreement that RNs spent too little time involved in direct patient/service user contact, with much of the fundamentals of care undertaken by health care assistants (HCAs) and the students themselves. For example, S2 suggested that, "all the qualified staff were in the office chatting and updating notes, not spending any time interacting with anyone," and later stated, "on the ward I just felt out on a limb because I felt like I was the only one that were taking time out to be with, to be with the service users."

S4 suggested that,

> I found that I spent more time with patients than the nurses did so they were actually asking me what the patients had said.

S4 also stated that, based on her experiences on one placement,

> A lot of the nurses, well, the newest member of the team had been there for three years, and there's a lot of the nurses been there for ten years, I think they've just got a bit lax? Bored? But don't get me

> wrong, some were, were good and did involve the patients and did go a bit of an extra step, but I didn't have a positive experience with some.

Picking up on this S2 stated that,

> I think the newer qualified ones were the ones that knew where you'd been and knew what position you were in and probably felt a bit sorry for you and took you under their wing a bit and can remember feeling like you did … and I found that they were also the ones with the drive and the passion whereas the older ones that had been there years just kind of came in, did the job … I'm making a generalisation, but the majority of the ones who had been there a while just kind of saw it as a job and kind of didn't feel anything for it anymore, and you could tell.

Both students recognised that they were making 'generalisations' but this perception was not isolated to one or two placements.

There were variations across the fields, and indeed across different placements within the same field, regarding the role and scope of practice of HCAs. S3 noted that on one placement,

> There wasn't a clear distinction between the health care assistants and the nurses erm, in the morning because all the patients were either 'wash themselves' or were washed each morning, got up, dressed, but the nurses did as much of that really with the health care assistants.

S3 went on further to discuss that HCAs on this placement fulfilled a lot of what she described as "nursey things". When asked to clarify what she meant by this, S3 stated that,

> Well, stuff like erm, doing blood glucose and some of the injections and taking urine samples from catheters and things like that. Coz some of the health care assistants had done extra training in specific things, so they were able to do erm, some of the more nursing roles.

Some differences in the perceived standards of care were noted between secondary and primary care with S2 suggesting that,

> I think like initially when I went on my first ward placement, erm, I was shocked at how erm, it's almost as if it's punitive and not caring. It's almost as if people are in there because they've done something wrong; and that's how it comes across, how they're treated. And I know I don't want to work on a ward. If I have to I'll do it, but I don't want to be part of that. I think there's quite a big lack of compassion, erm, whereas in the community, you've kind of, yeah you're in a team, but you can be more creative and you can spend as much time, obviously within reason with people and doing how you think that kind of they'll respond to. I think it's a 'one size fits all' on a ward, erm and I think in terms of like the qualifieds seem to spend a lot of time in the erm, office doing paperwork and it'd come to handover and they wouldn't actually have seen that person but yet they'd be handing over.

Within the constraints of this study there is no way to verify these accusations, nor give the relevant RNs a right to reply. However, the perception of the students and the effect that it had on them is significant. The following quote offers some insight into another concern expressed by the students across all four meetings; a worry that they may become 'normalised' to what they saw. As S1 stated,

> I'm worried about becoming one of them, because you're surrounded by that kind of attitude about other people, from them and you kind of want to keep a bit quiet. But I just hope that I don't turn into that by, coz if you're constantly surrounded by that kind of thing do you without even knowing it turn into that? I don't know, it's worrying.

The moderator provided some information on discussions he had had with a local Director of Nursing,

> One of my very close friends is one of the Directors of Nursing and she has said, 'I want to come and do some work with you', because she knows that the values of students get normalised, not necessarily always in a positive way, very quickly by the experiences they have out there.

There was clearly some recognition by a local Trust that this kind of negative influence

on the students was occurring, and they were attempting, at least in part, to manage it.

There was definite recognition that negative experiences like these could still be valuable learning opportunities. As S2 stated,

> I think it makes you more motivated and more determined to not be like that. To be, 'right, I've seen how you are with these people and there's no way that I want to be like you,' so it kind of seals your determination in a way, doesn't it? ... It kind of makes you think, 'there's no way I'm going to be like that,' I suppose; I suppose it's good even though it's not a great experience; if something good is coming out of it then it's worth, it isn't it?

In a similar way, at a subsequent meeting, S4 stated,

> Seeing good nurses and bad nurses and going, 'I don't want to be like you and I do want to be like you,' and those sorts of things that's really interesting, that's really good, it gives you more of a drive, you know really to do it.

What was apparent across all four meetings was that the students felt confident enough from an early stage to critique the role of the RN and the standards of care they witnessed. However, what was not articulated by any of them was whether they had had any discussion regarding their concerns with colleagues in clinical practice. Would they have 'quietly got on with it' and not said anything if they had not been granted the opportunity of participating in the focus group?

The students did not present an entirely negative view of practice. There were examples of good practice that had a positive impact them. S2 provided one such example, and although this is from her own personal life, it highlights the impact that this had on her.

> I think it usually depends on where you are as well [agreement from the others]. Like my [relative] was in [location] and like I'd been told that all the nurses there were really good, but I've just never seen anything like it. They were absolutely amazing. You just kind of think,

> that's the nurse that I want to be … I want to be that nurse that everyone says, 'God, she's a really good nurse, she's lovely, she's got this, she's got that, she's;' so I think it depends where you are.

Degree/graduate status

This theme centred on the aspect of the students being undergraduates. The fact that they were now on an undergraduate programme was not discussed in clinical practice. What was an issue for S3 was the fact that she felt 'uncomfortable', at least initially, with being a degree student in clinical practice as the following extract from the first meeting illustrates,

> **S3:** I suppose I'm going back quite a long way but, you know, when you trained to be a nurse just in the hospital then it would have, they would be more, everyone in the hospital perhaps would be more aware that you were learning as you go. I don't know, this thing about doing a degree just…
>
> **MODERATOR:** So do you think there is something about that change then that has…?
>
> **S3:** I don't feel comfortable with it because I, but I'm…
>
> **MODERATOR:** Comfortable with what?
>
> **S3:** Erm, I don't know, just this. I don't know, maybe it is just something to do with like status and rank and all that sort of stuff, really. I would have felt better going into the hospital and learning as a, you know, with humility, like I've come, I don't know nowt and just teach me, then; there's just something about that I'm, that you're doing a degree. But maybe that's just coz I think too much about stuff like that.

Inter-professional working

The focus of this theme was the students' experiences of inter-professional/collaborative working in clinical practice. A quote from S3 during the second meeting highlights some of the discussions,

> It seemed like the nurses were on the defensive still in terms of like they were having to fight for respect from the other professions. I don't

know if that is real, but that's how they, what they were communicating … They perceived themselves as being the ones that got all the shit if owt went wrong.

Similarly from S3 during the third meeting, discussing the same placement area,

That was [a] very multi-disciplinary ward, I mean, all the time so the nurses would be saying this about the therapists, you know like, 'well they're sitting round there. They never answer the telephone,' you know, there was a real sort of power struggle thing going on and I think the nurses felt like they did more work and they were the skivvies and the therapists thought they were a bit better. But then they still worked effectively with each other.

S4 used the multi-professional working opportunities to her advantage. She stated that,

I went with the physios a few times erm, and I felt easier with them then, they were, they actually had time to speak to me and they would explain everything that was being done and they would explain what their role was and how they linked up with us. They had lot of time for me and I felt part of a team with them.

During the third meeting, there was some discussion on the role that the RN fulfilled as part of the multi-disciplinary team.

MODERATOR: So what role do you think nursing plays within the inter-professional context then?

S3: Erm, like the bedrock really. Like the therapists were doing the specialism … sort of the physios were doing a lot on the erm, they would go in and do the therapy sessions on the breathing or the lungs or whatever, but the nurses would be doing the suctioning 24/7 when they weren't there, you know, erm so the nurse would have a much more sort of consistent, longer term view of the patient's condition or you know, erm, whereas a therapist would go and do specific therapeutic things that were erm, so objectively, everyone had a really important valid part to play in it.

S1: The nurse is always there, do you know, with the patient, there's always the nurse in charge of the patient. Other people coming in, I think.

This portrays a rather 'hospital-centric' view of the role of the RN and links with the clinical experiences that both S1 and S3 had had to that point.

Placement

This was a key theme that ran across all four meetings and had a number of sub-themes. Its focus was the students' experiences in clinical practice. Some of these have already been discussed under other themes, but there were distinct aspects here that made this theme unique. Not least were discussions on the relationship between the student and their mentors, including the time spent working alongside them. During the second meeting the students were asked if they had spent 'a lot of time' with their mentor.

S2: No. Probably, no, not as much time as I'd liked. I think she were off sick for quite a bit on my hub placement …, but I tended to stick to the nurses that, I kind of followed the shift patterns of the nurses that I liked the way that they worked and it kind of worked. They were mentors as well, but just not my mentor, so possibly my co-mentors, but I kind of observed a few different people and went out with a few different people which I think was really good to see how different like people do their jobs basically. Even though they are doing the same jobs they go about it in completely different ways so I think that were good.

[…]

S3: In the beginning I had quite a lot of time with my mentor, in terms of we were on the same shift, but you'd soon get into a shift and I'd be off certainly in the beginning a lot more with like the health care assistants.

[…]

S4: I spent a lot more time with my co-mentor and my co-mentor did my like initial interview.

S3 suggested that she would have preferred a little more structure and direction from her mentor, “there was no direction offered necessarily from the mentor, you know, erm, they were just fitting the bits in of learning when, if and when really.”

S2 stated that one mentor had suggested that she needed to be selfish,

> My mentor, on my first shift that I spent with her, she said, ‘just be selfish about it,’ …, ‘you will get caught up in I need someone or I need an extra body in this,’ …, ‘but you’ve got to think that if you’re not getting owt out of it then say no, you don’t want to do that coz at the end of the day you’re not in the numbers and you need to be like putting your foot down and saying how’s that helping me? It’s not so;’ I think that gave me the confidence then to think ‘oh well, if she’s told me to do that then, obviously I’m gonna do that.’

There were similar responses during subsequent meetings,

> **MODERATOR:** So, from a sort of mentor perspective, then, did you work very closely with your mentors? From very early? As in immediately?
>
> **S2:** No
>
> **S3:** Very variable, mine was.
>
> […]
>
> **S2:** I didn’t have very much one to one time with my mentor at all ... some night shifts I’d go on and she’d say things like, ‘Don’t ask me questions tonight, I’m knackered,’ and I kind of got the feeling that she couldn’t really be bothered, and so I’d choose the people who I knew were really good at explaining things and I’d match to the shifts when they were on. So I kind of stuck to them and got more out of them than I did out of my mentor.

However, S1 had a much more positive experience. She stated,

> I spent nearly every day with her. Every time I worked, she worked erm, and on the ward I was on, they split it up so erm, she’d have a section to herself and then she’d give me part of her section, do you know so that I might look after like two children. She might look after

> the other four, erm but she'd always be there like if I needed her, but yeah, I spent a lot of time with my mentor and it was really good, coz the ward weren't that busy so she had a lot of time to go through things with me. She taught me a lot.

In a later meeting S1 said,

> I've been really lucky in all my mentors have been really nice and supportive, whereas, erm, I know from speaking to other students that not all mentors are like that, so I dread getting a mentor like them.

It was also clear that S1 was proactive and adopted a positive approach to her mentors.

> What I do erm, when I meet my mentor, we'll have like a conversation and I ask her what she expects of me as a second year nurse, and then, I said to her, 'if I came back as a third year what do you expect of a third year nurse,' so I was thinking, 'erm, I can try and do;' so I was doing a bit of what she expected of a third year erm … but I've got confidence now I will ask that of a mentor, 'what do you expect me to be doing now?'

There was some sympathy for the workload that mentors had. For example, S3 suggested that,

> My mentor, she has a perpetual stream of students and she'll have three or four that she's mentoring at the same time and she wasn't the most communicative woman. I don't think she chose to be doing that necessarily erm…

Due to some of the gaps left by her mentors, S4 took the opportunity to work alongside agency staff.

> Because they weren't busy with everything else that the other nurses had to do they were like letting me practice blood pressures on them and they were doing other things that I needed signing off that I wasn't getting to do on the ward.

This was followed by a feeling of having more responsibility. As S4 explained,

> When I had a bank or agency nurse they let me do the hand-overs because I knew what had been going on more. I could erm, and I was

> telling them what like routines were, what was set up for people, particularly autistic patients had set routines of how we did things, and I was able to tell the bank and agency nurse well this time is when they have their medication and they have this after it and not before it otherwise it can create more anxiety for them. So, in a way it was, it gave me more, I don't know; it gave me a bit more responsibility.

The general lack of support and direction from mentors was undoubtedly at the heart of S3's feeling at times of being, "an annoying addition." She stated,

> I was like an annoying addition to a very stressful busy job and other times, you'd just be like, and at other times, they were really keen to actually teach me stuff, so that was very varied really.

What was apparent across the four meetings was the increase in confidence that all four participants articulated. For example, S4 journeyed from being frightened of answering the telephone to,

> I was so much more confident in my placement, so, and my mentor was really good at letting me sort of get on with things as well. I was able to like go back to my mentors and suggest things that could actually be changed and they were actually listened to and some of them were actually done and that was really good. It made me feel really good about myself,

When asked where this confidence came from,

> **S1:** I think knowledge and erm, I don't know.
>
> **S4:** New experience, as well isn't it, you know?
>
> **S2:** I think it's like having a new situation where you feel like you're starting a new job every time and that at first that's really awful and really daunting coz you've got the lack of knowledge on top of starting a new job with new people and you get some people that have not got great attitudes either, I've found, and erm, I think the more you're put in that situation. It's like being in your comfort zone and the more you step out of your comfort zone the more that becomes your comfort zone, doesn't it, so it's like, you're going back to that new, you're going to a different situation, a new situation, but you're kind of like, 'oh well

> this is the same job.' It's not like, 'Oh my God, it's just;' so I think a lot of it is to do with just how we come across when, do you know what I mean?
>
> **[General consent from the others throughout]**

Some of this increase in confidence came from the on-going development of clinical competence and the students discussed what they had learnt on placement. These discussions included the opportunities they had had to practise the clinical skills taught in university. However, this increase in confidence did not stem just from clinical experiences, and had wider implications. As S3 stated,

> I think my confidence in my own; that thing that you [S2] said about nurse's confidence, what was it self-esteem? I think before I started this my self-esteem in terms of my academic ability wasn't amazing, and my memory. I think the more I've studied actually the more confidence I've got in my potential and I'm more, become more in terms of testing the kind of, I don't know, scientific side of it really in terms of the medicine side of it, so I think my view of my potential has changed therefore my view of which roles I could do within nursing changed.

The pressures and emotions of clinical practice were apparent when three out of the four students admitted to crying on at least one occasion. S4 recognised a possible solution to her tears when she claimed that,

> I think I actually learnt in a sense not to care quite as much because I can't for the rest of my life go home crying coz I'm sad about someone's story, so in that aspect I do have to toughen up.

S1 felt the pressure of trying to make a good impression on staff in an area where she wanted to work once qualified. She said,

> I used to get out of shift and walk. It was a ten-minute walk back to my [relatives] and I used to just cry, but I weren't crying coz I were, nothing had happened, I was just exhausted and, but because I only had four weeks there I felt like I had to really, coz that's where I want to work, so I had to really make a good impression…

There was general agreement that, given time, each considered themselves to be part of the team they were working with. S3 stated that,

> I feel like you have to work a bit to be accepted as part of the team you know, you have to like show yourself and you have to take risks … It felt important I got properly stuck in.

S3 also expressed frustrations at being referred to as, "'the student' when you have been there for eight or nine weeks!" Despite these frustrations and some concerns over the relationship with some mentors, all of the students acknowledged that they had enjoyed their placements and that they had learned a great deal.

Pre-course caring experience

This theme resulted from discussions held during the third meeting. This third meeting was held between the publication of the Francis Report into the failings at the Mid Staffordshire NHS Foundation Trust (Francis, 2013a) and the UK Government response (DH, 2014). Prior to the publication of the Government response there was a great deal of rumour and debate in the nursing and general press about the content of the report, not least in relation to the expectation that prospective nursing students had to have a significant period of health care experience before applying for a nursing programme. Therefore, the focus group discussions relevant to this theme centred on one of the proposals emanating from these reports and the discussions around them. As paragraph 23.55 (Francis, 2013b, p.1515) states,

> There needs to be a requirement for a minimum period of experience in the hands-on, fundamental aspects of care to provide an opportunity for aspiring nurses to demonstrate that they have the capacity to be compassionate in practice. What is required is a better opportunity for potential recruits to the nursing service to develop experience in the fundamental but essential tasks involved in hands-on care of physically and emotionally vulnerable patients and to demonstrate their vocation and the values that all good nurses should have.

No time-scale was set for this 'minimum period' but the inference is that this occurs prior to the student commencing their degree. The UK Government's response to the

Francis Report published in January 2014 (DH, 2014, paragraph 5.24, p.98) states that,

> One of the most important things for securing compassionate care is making sure at the outset that the right staff, with the right capabilities and values, are recruited into posts involving direct care. The Government has asked Health Education England to test the concept of up to one year of pre-degree care experience for aspiring student nurses, so that they are able to work out whether the career is suited to them, prior to starting a full nursing degree course.

The wording here suggests that the rationale for the clinical experience is to allow the prospective student an opportunity to establish that nursing is, indeed, 'suited to them'. This seems to present a different emphasis to the statement from the Francis Report highlighted above which suggests that the rationale is to allow the students to demonstrate compassionate care and develop, "the values that all good nurses should have," (Francis, 2013b, p.1515).

The students in the focus group offered a different perspective. S1 suggested that much of the content of the first year could be reviewed if all students had prior health care experience,

> If everyone had that experience, a lot of what we got taught, probably we could sort of go over rather than actually teach it.

S4 stated,

> I think it's useful having that care background, because even in your first set of lectures you're able to think about what you've been doing within a caring role and you go, 'yeah, that does link in with that; yeah that does link in with that,' … it's really useful in that first year.

Some concerns were expressed about any possible inflexibility in the implementation of this recommendation. For example, S3 stated that,

> I think having any kind of regimented thing is a bit tricky, you know, like there's people who've left careers as an older, as a mature student, you know, it's hard enough affording three years without getting paid to add another year to that, and also people, and so then

> you might not get certain people who've got experience in other things and transferable experience, so I think there should be some room to be able to convince the people that you've got enough relevant experience.

S3 later added that,

> If I'd had the luxury of time I would like to have done a year as a health care assistant first.

In a previous focus group meeting S3 had expressed concerns about feeling unprepared for clinical placement,

> I felt like, 'what am I doing; who do I think I am coming up and being a nurse when I have never been a health care assistant?'

This provides insight into the fact that this student felt that in order to feel justified in her role as a student nurse, she needed to work as a HCA first. S2 acknowledged that she had never worked as a HCA but did not feel as if she was, "struggling." She placed more emphasis on the benefit of excellent interpersonal skills rather than direct care experience.

S3 did offer an additional benefit, in her opinion, to prospective nursing students spending twelve months as HCAs. She stated,

> The other side of it which could work well is that if people have had experiences of, if all nurses had had a year as a health care assistant, their empathy and respect of health care assistants may be improved.

<u>University – Theory</u>

This theme focused on the theoretical element of the programme i.e. that which took place within the university setting. The students generally felt well supported throughout the programme. There were some issues with individual modules, but these were usually resolved by direct contact with members of the module team. S1 was a student rep and stated,

> There is a lot of support in the University. I think because I'm a rep so I went to a training and I know where all the support is so I do like, I'd

know where to go, erm. But then I'd hope that students would come to me if like they wanted to ask…

There was some initial hesitation in meeting their personal tutors early in the programme. A session was included during induction which introduced students to the role of the personal tutor and provided them with the name and contact details of their allocated personal tutor. The students were actively encouraged to book an appointment early to meet with their personal tutor, however, there were delays in establishing this important academic support relationship.

One student had made a brief initial contact with her personal tutor but had 'messed up' booking an appointment as the following excerpt illustrates,

MODERATOR: Can I just reiterate then this about erm personal tutor then? I'm right in assuming then that you've all, you've all had that foundation in that relationship then, already you've met and?

S1: Yeah.

S3: Yeah, I've messed mine up coz I had an appointment with him yesterday and forgot, so, but the potential, the opportunity was there.

MODERATOR: So you've not met them yet?

S3: I went and knocked on his door and said, 'Hello you're my personal tutor,' at the beginning, so I know who he is and then I made a, I booked a thingy in for yesterday.

MODERATOR: And is that mainly because you haven't really felt the need to speak to them or is it because you're not thinking that he's now going to be, he's now cut you adrift coz you…

S3: No, no. My tutor does more third year stuff so I do think I'm a little bit. You know, I think if he'd been my tutor, if he'd been lecturing us and stuff a bit, I might have felt a bit more erm, a bit at ease with it, but no, I think, yeah, I just messed it up, that's all.

What is significant here is the student's assertion that she would have felt easier if she knew the tutor a little better. Indeed, the same student admitted approaching another nurse educator who had taught her in year one. She stated,

I had an issue that I've just been to see [Senior Lecturer] about. She's my link tutor, because I feel like I've got more connection with her than

> my personal tutor. Just in terms of, I know that they go on about that. We have to be assertive and we have to assert these relationships and all that, but there is a lot of new stuff going on for us and, maybe I'm just, maybe I'm negating my responsibility if [pause] I think I would have appreciated my personal tutor or the, making contact and saying come and see me.

The rationale behind these early meetings was not apparent to some.

> **S3:** I put off making an appointment coz I didn't know what to say to him. Which was silly really, I should have just gone…
>
> **S4:** You don't quite know what you are meant to be talking about; a sort of hello?

S1, however, had been to see her personal tutor. She stated,

> I did feel like I went to see my personal tutor erm and like we've set some objectives and stuff and I did feel like that was really useful.

The largest sub-themes related to the students' feedback of the delivery on the theoretical components of the programme. There was a lot of discussion around the lack of meaningful interaction during lectures, especially when certain lecturers were involved. One typical excerpt included,

> **S3:** I've had a really mixed experience of lectures. Some I've found brilliant and some I've just, had to bite my tongue and have just like found it quite infuriating on different levels. One being, just being talked at for the entire time with no space for interaction and also when someone puts up a PowerPoint and then talks….
>
> **S4:** Reads the PowerPoint.
>
> **S3:** …reads the PowerPoint and there's some lectures and I've just thought I could just stayed [*sic*] at home and read the PowerPoint and then others that I've left and the time's flown by and it's been amazing.

In relation to this, there was considerable discussion on how the students perceived that some lecturers did not like to invite questions or 'be challenged'. The following excerpt, whilst lengthy, is included as it includes input from all four participants,

S1: They don't like you speaking do they?

S4: Yeah, you speaking up, and I know they've got to fit it in within the amount of time and get through a certain amount of slides or whatever like that, but the slides are on Unilearn and you can't…

S2: But some people do manage to take people's comments on board and be positive about them.

S4: Some are fantastic.

[Various voices – Yeah]

S2: Some manage bouncing them back and [pause]. It's almost as if you have a personal, you're personally challenging what they think, not what the lecture's about and it sometimes comes across as, 'oh, I daren't say owt else,' do you know what I mean? It's a bit. It's not erm. It's, it doesn't feel safe to challenge some things that are said in lectures.

S1: That's only some of them.

S2: Some of them, yeah.

MODERATOR: And would you say that's consistent with, you know so if that's happened once with a lecturer you would anticipate that it would be the same next time? Is that…

S1: With that lecturer?

MODERATOR: Yeah.

S1: Yeah.

MODERATOR: And how do they, how do they, sort of you know present that block then? You know, how does it feel to you as a student?

S2: It feels like…

MODERATOR: How do you know?

S2: …they're turning it around and making you feel stupid for asking the question, sometimes, I think.

S3: Very defensive, they get very defensiveness about it.

Information overload was another factor discussed by the students. S3 stated,

> Another thing is it just feels like I'm not; you get that much information thrown at you actually in terms of learning, personally I can only speak personally, I would learn more doing less more thoroughly, then just this bombardment of all this stuff at you like that so you don't get to actually experience it or enjoy the experience of learning.

Similarly, S1 stated that,

> I think I was so glad to get out working [in clinical practice] coz it was just so much information like [pause]. Just like lectures, do you know like from September to like December; a lot of information to take in and just reading and so when we like, not that we don't come here anymore coz we do but we are actually in placement like working, seeing things and talking to your mentors 'n' it's just such like a brain release.

At the heart of much of this was a lack of engagement with their learning. The students perceived that the learning experience, and indeed the amount they retained would be greatly improved if they were more engaged in and had an emotional connection to the learning experience. This, they felt, was better achieved through seminars, "The research seminars, I love them. I love it when we get to be engaged in our learning experience," (S3). This was particularly the case for 'field specific' sessions. S2 stated that, "we found it so [emphasis] useful just to be in our [field] and ask questions that was specific to mental health to like to prepare us for placements." S4 agreed suggesting,

> I think it's brilliant because, and we've only had, what four field specific, like skills, between the skills and the lectures, but it's been brilliant because we've been doing case studies based on a girl that [Senior Lecturer] has got information about. It's allowed to be used for teaching purposes and it's like you are actually doing a proper assessment and, but, you're doing it in a safe environment where it doesn't matter if you assess something wrong because it's not actually doing anything and you've got your tutor to turn back to.

The use of simulation as a teaching and learning strategy was discussed briefly across the four meetings. Initially the feeling was that they had spent too much time either observing, or left on their own during unsupervised practice. As S3 stated in relation to a session on personal care, “It was a great observation, but we didn’t get to practice.”

5.6 Qualitative data: Nurse educator focus group

One focus group was held with four nursing educators participating. Throughout the presentation of results and subsequent discussions, the educators are referred to as E1 to E4. Their field of nursing is not identified to reflect their leadership roles across the whole course.

5.6.1 Phase one analysis

The question guide for this focus group can be found in Figure 5.7. The initial discussions centred on the participants' attitudes towards the move to an all graduate entry. Everyone was in favour and cited equity with other health professions as being key. All four participants agreed that 'care' was more complex now and health care needed a more questioning, assertive, critical thinker. E4 stated that they had not noticed much initial difference between students on the degree programme in comparison to students on the previous diploma programme, but had noticed a significant difference in their criticality during their second year. It was acknowledged across the group that it was unlikely that any real difference would be noted to start with. Entry criteria were comparable with the previous diploma programme, the students were still orientating themselves to the programme and most were new to higher education. There was an increased emphasis on research and on critical thinking from the very start of the programme, which was felt had led to the increased criticality noticed in year two.

In an interesting discussion, E3 felt that increased levels of support would be required to aid the students with the transition to their first RN role. There was some discussion on the fact that the university had offered degree level pre-registration nursing programmes for many years and therefore students had already made this transition. Local employing organisations should be equipped to manage it. However, E3 felt that a key difference now was that all the student nurses were on an undergraduate programme which altered the dynamics in class and the educator's approach. There was also increased emphasis on critical thinking and a suggestion that the students would be more confident at point of registration. Colleagues in clinical practice needed to be prepared to receive this 'new breed' of qualified nurses.

These focus groups are not group interviews as such as I am interested in utilising the interaction between the lecturers as the group explores their different experiences. The questions will be guided to some extent by the issues raised, but will address areas such as:

Opening question

1. For the purpose of the recording please let me know your name and role.

Introductory question (Introduce the topic and get the participants to start thinking about the issues)

2. Although it is now some time since the decision to move to an all graduate entry to nursing was made, I would like to explore the group's attitudes and thoughts on this. Perhaps at some stage you may wish to use this quote from the NMC (2010a). According to the NMC (2010a, p8),

   "Degree-level registration underpins the level of practice needed for the future, and enables new nurses to work more closely and effectively with other professionals."

Transition questions

3. What were your expectations of the students from the September 2012 cohort and do you feel these expectations were any different from previous cohorts?
4. Have these expectations been realised do you think?

Key questions

5. Can we focus on the curriculum here at this University? I would like your thoughts on how it has run so far, any unforeseen issues that there have been, what has gone well etc.
6. Turning to academic and pastoral support, how much support has this cohort required so far, more than previous cohorts, about the same, less than previous cohorts?

Ending question

7. There is evidence to suggest that an increased entry criteria will lead to a reduction in attrition. Although we are not discussing specific local data here has this been your experience?
8. We have discussed your experiences with the September 2012 cohort so far. Before we finish is there anything I have missed or anything you would like to add?

Other follow on questions will be linked to the answers obtained all focused on the students' experiences on the course so far.

Figure 5.7: Question guide for nurse educator focus group

The increased level of inter-professional learning (IPL) was viewed as significant. Students were 'made' to work together in inter-professional groups. Linked with the increased IPL were concerns expressed by some students to E3 regarding a loss of identity with their own field of nursing. Other members of the group expressed an element of exasperation about this. Emphasis was placed on the fundamental aspects of care and there was some criticism of the 'too posh to wash' accusation aimed at some degree nurses. What was seen as important was that the students understood

the background/reasons for the care. E1 stated that they felt sorry for the September 2012 cohort as they had been 'guinea pigs' for the new programme. E1 also expressed concerns that in dealing with some of these frustrations, students from the September 2012 cohort had, on occasions, resorted to unprofessional behaviour.

Pastoral care was important, and there was some debate as to whether the level of pastoral care required had increased or not.

Finally, there was some discussion on the issues and potential problems of summative grading in practice and the evidence from other professionals where this already occurred.

5.6.2 Development of codes and themes: Nurse educator focus group

Phases two to five (Braun & Clarke, 2006) identified a number of themes and sub-themes for this focus group (Figure 5.8). The figures in brackets refer to the number of references for each sub-theme.

Students
- Assertive (3)
- Critical thinking (7)
- Identified as nurses (4)
- Preceptorship/Mentorship (9)
- Self-directed study and practise (2)
- Transferable skills (9)
- Use of evidence base (2)

The course
- Academic and pastoral support (10)
- Attrition (4)
- Care, confidence, compassion and competence (15)
- Guinea pigs (3)
- Review (4)
- Workload (2)

Clinical practice
- Changing view of nursing (8)
- Grading of practice (8)

Degree v diploma (21)

Inter-professional learning/working (15)

Figure 5.8: Themes and sub-themes (nurse educator focus group)

The themes identified were unique to this focus group but there were clear links with some identified from the student focus group.

5.6.3 Further details of themes

Clinical Practice

This theme focused on the discussions on aspects of clinical practice. There was general consensus that the acuity of patients had increased and length of hospital stay had decreased. As a result, it was felt that students needed to, "hit the ground running," (E3), whatever the care setting. Participants had also noticed a trend where a number of students on completing the course were securing their first RN posts in primary care,

> **E4:** If it follows the same trend for end employment which [the September 2011 cohort] have just gone through a significant number of first time appointments were in primary care.
>
> **E2:** Yeah, we've got quite a few this time.
>
> **E4:** And you would imagine that, you know will continue.
>
> […]
>
> **E1:** And that's a change in mind set as well from the staff out there, because not going back, not too many years ago I probably wouldn't have been here if I'd have been accepted for a community job but I wasn't accepted coz all my experience had been in acute care. 'Oh no, you can't be coming out here…,' to what was then an E grade, '…with not having worked in community.'
>
> […]
>
> **MODERATOR:** Or even get a job as your initial job after registration. It was the standard then, wasn't it, 'Go get some ward experience.'

Some concerns were expressed regarding the issue of mentors grading students in clinical practice, an aspect that had been introduced at the start of the all graduate curriculum. For placements in year one and two, and the first placement in year three, the grading was formative, based on criteria devised by another local university. However, the grade given in the final placement in year three was summative and this was causing some anxiety. As E4 stated,

> I target the mentors [on the Supporting Learnings in Practice course] that are coming through … about grading in practice, because they are going to get it. And we see the variances in gradings at the

moment from first years and second years and I just think I hope that is going to iron itself out by the time we get to the final one.
[agreement from others].

Degree v diploma

There was clear consensus amongst these participants that the move to an all graduate entry was a positive one, and all highlighted equity with other AHPs as a key reason. All four participants had facilitated mentor updates in the time leading up to the introduction of the programme and all had received some objections from clinical colleagues.

E3: When we have been talking about we're introducing an all graduate profession I would say there is some resistance in practice, and probably erm, the erm, the qualified nurses feel a bit threatened if they have not been qualified to degree level so I think there is definite … that isn't just an isolated case. It's happened on a number of occasions.
E1: I have experienced the same.
E4: I have experienced the same as well.

Significantly, E2 offered a different perspective, "I come at it from a community background and when I do community audits, they, I've found them quite embracing, quite welcoming, I think because they recognise that district nurses are leaving rapidly now."

There was general agreement that a clear difference in the level of critical thinking had been noted from previous cohorts. This cannot be verified as part of this study as no tool was used to measure the critical thinking of either this or previous cohorts, but the perceptions of these participants were clear enough. The difference had started to be noticed during year two, and it was felt that this was due to the fact that the students had been introduced to the research process and been encouraged to 'think critically' as undergraduates from the start of the programme.

E4: I think they've been through specific research things as well, which I think has had an impact on them understanding evidence…

> **E1:** Yes, yeah, I think the impression I had from previous cohorts … with research was something you just got to grin and bear it. Just get over this module, write the assignment and it's all done with, whereas they [September 2012 students] are much more immersed in the process now, right through year one and year two and it's going to be year three.

Inter-professional learning and working

The theme of inter-professional learning/working was prominent. E1 stated that as a result of increased IPL,

> Hopefully there will be greater understanding, greater multi-disciplinary team working, communication, all the rest of things that can enhance patient care … I think unless you are almost forced to work with other professions … then you don't. You still stay in your little silo and stay with all the nurses, or with all the physios, or with all the OTs or whatever and never the twain shall meet, and as much as it's been painful for some of them, and it is painful isn't it? But then some people say learning is painful [laughs]. They have been 'made' to work together and all those research groups that they are in now like in year two and they are going to be in the same groups in year three every single one is inter-disciplinary in some form or another.

E4 recognised the benefit of understanding what each AHP's role actually was and stated that,

> I think the more you know about something, the more you know about somebody, the more you understand why they do certain things and I think that's going to come through.

E4 further suggested that this process would help improve how nursing was viewed by other AHPs,

> Maybe hopefully that, because they are doing inter-professional learning, those other inter-professionals will then look upon us [nurses] in a more professional light because they are actually seeing what we're doing and how we're working. We're working with them,

> whereas before as [E1] said, maybe there was a case of education in silos.

Students

This theme focused on the educator's perceptions on how these degree level students were 'different' from students in previous cohorts. There was general consensus that their critical thinking skills were more developed. The students appeared to be more assertive, but there were concerns that students had, on occasions, allowed assertion to become confrontation and had acted unprofessionally with academic staff when raising concerns they had with particular modules. Participants also commented on the increased emphasis on primary care in the 2012 curriculum and how this had improved the range of 'transferable skills' the students acquired linked with recognising the scope of practice within primary care.

The course

A link between the theme of 'students' and this theme was the issue of academic support and pastoral care. E4 stated that,

> I think they, the pastoral things that have come to me have all been the same … They all suffer the same anxieties and stresses and worries and problems at home and illnesses. It all repeats and I don't think that's changed. I think we still do what we do in supporting them as human beings who have problems, don't they?

E2 disagreed suggesting that,

> I think pastoral support has grown, which it should do as well. We get a lot of young people coming in, and they need lots of support, but we do do a lot of pastoral work. And we send them to the right people now because we've got more of an awareness of where people should be going.

E1 expressed some sympathy for the September 2012 cohort, identifying that in many respects they had been, "guinea pigs." This is perhaps inevitable with the introduction of any new programme. The participants acknowledged that changes had been made prior to the September 2013 students commencing the programme.

5.7 Qualitative data: Student questionnaire (Question 30)

Question 30 asked the participants to 'Please write about why you wanted to become a nurse'. Of the 150 participants across the four fields of nursing (Adult [A] =77, Child [C] =19, Learning Disabilities [LD] =17 and Mental Health [MH] =37) who completed the questionnaire (88% response rate), nine participants (6%: C =1, LD =4, MH =4) did not give a response to this question, with one other participant stating that they would, "prefer to talk via 1:1 interview. Difficult to articulate on paper." (S54[LD]). Here 'S' identifies the participant as a student. The number, between 01 and 150 was randomly allocated to all participants, and the letters in square brackets refer to the field of nursing that the participant was studying.

5.7.1 Phase one analysis

Of the remaining 140, 86% (n=121) included reference to their desire to 'make a difference', 'help people' or 'care for people'. Twenty respondents acknowledged that working in healthcare, particularly nursing was something they had always wanted to do. For others, the inspiration came either from their own experiences of healthcare, from participating in the care of others, often close family members, or through witnessing the nursing care given to others. For some the inspiration was actually seeing poor nursing practice/care and wanting to improve on this.

The financial rewards of nursing and job security were also mentioned by a handful of respondents, but often after the factors discussed above. A number highlighted the desire to gain a professional qualification and learn new skills/knowledge as an additional motivation for undertaking the course.

This was not just a 'rose tinted spectacles' view of nursing. A number of respondents had previous healthcare experience and all had had at least three different placements since the programme began. They knew the realities of healthcare in the twenty-first century. What shone through many of the responses was a passion for people and a passion for nursing.

5.7.2 Development of codes and themes: Student questionnaire, Q30

Phase two of the data analysis process identified the codes shown in Figure 5.9.

A desire to help	Make a difference
A privilege	Not boring
A recognised professional qualification and knowledge	Nursing is always changing
A respected career	Passion
Advocate	Personal experience as an influence
Couldn't see myself doing anything else	Previous work experience
Educate others	Proud
Enjoyment	Provide a good service
Finance	Something I have always wanted to do
Fulfilling and rewarding career	The 'six Cs'
Giving something back	The grades were obtainable
Go to university and get a degree	Vocation
Improved career prospects	Witnessing good care
Influence of relatives in the healthcare professions	Witnessing poor care
Learn new things	

Figure 5.9: Phase two codes (student questionnaire, Q30)

Progression through phases three to five identified the themes and sub-themes shown in Figure 5.10. The figures in brackets refer to the number of references for each sub-theme.

5.7.3 Further details of themes

Altruism

The title of this theme was chosen as it portrays the image of someone giving of themselves, beyond any benefit that they may gain. Sub-themes like 'a desire to help' and 'make a difference' were prominent. Some participants recognised the 'cliché' or 'typical' nature of these desires, suggesting, "It may sound cliché, but I enjoy helping people," (S06[MH]), and, "May sound a bit typical but helping people to become well and achieve their potential drives me forward," (S16[MH]). Some students highlighted the privilege it was to be able to care for others. S134[A] stated, "I think it is a great privilege to be beside people in their crucial life situation and to be able to be an advocate for [a] patient," and similarly, S147[A], "I think that to be able to care and to be trusted to care for someone in their most vulnerable and scariest time of their life is a privilege." It could be argued, of course, that the students were telling me what

they thought I wanted to hear, but I was careful at the time of distributing the questionnaire to ask them all to be honest, and reassured them that their responses would not affect their continued time on the course. The term 'vocation' only appeared in one response, with S95[A] stating, "I strongly believe nursing is my vocation." S85[A] sparked ideas of the historical religious order background to nursing when they suggested, "After a year of working in a care home I believed my calling in life was to be a nurse."

- Altruism (162)
  - A desire to help (41)
  - A privilege (4)
  - Advocate (3)
  - Educate others (1)
  - Make a difference (47)
  - Provide a good service (1)
  - The 'six Cs' (64)
  - Vocation (1)
- Career prospects (48)
  - A respected career (10)
  - Fulfilling and rewarding career (27)
  - Improved career prospects (11)
- Previous Experiences (69)
  - Courses (4)
  - Family (13)
  - Personal experiences (8)
  - Witness the care of others (20)
  - Work experience (4)
- Finance (5)
- Personal development and fulfilment (93)
  - A recognised professional qualification and professional knowledge (6)
  - Couldn't see myself doing anything else (4)
  - Enjoyment (17)
  - Giving something back (8)
  - Go to university and get a degree (3)
  - Learn new things (16)
  - Not boring (5)
  - Pride (6)
  - Passion (8)
  - Something I have always wanted to do (20)
- Relatives in the healthcare professions (14)

Figure 5.10: Themes and sub-themes (student questionnaire, Q30)

Some of the references to making a difference highlighted a desire to have an impact on society more generally. For example, S12[MH] stated, "I felt that my involvement as a healthcare professional could make a difference in reducing stigma, challenging prejudice," S48[LD] desired, "To make a difference to the future of LD nursing and to improve current practice." S73[C] suggested that there had been, "lots of negative media about nurses and their lack of care and compassion and I don't like the thought of this happening so wanted to do something about it and change perceptions."

The ‘six Cs’ (DH & NHS Commissioning Board, 2012) featured in many of the responses, either in the form of an action; to care or to be compassionate, or in the form of an emotion/sense of being; ‘I am caring’, ‘I am compassionate’. Cited below are examples from each field of nursing.

- “I love caring for people and think that it is important for people of all ages to be cared for equally with respect/dignity,” (S124[A]).
- “I am a compassionate, caring person,” (S78[A]).
- “I wanted to care for poorly children,” (S71[C]).
- “I am very caring and compassionate about caring for individuals,” (S60[C]), who managed here to combine both the action and the state of being.
- “To be able to provide good quality care for people with learning disabilities,” (S45[LD]).
- “I also feel I am a caring, compassionate person so I could therefore make a difference,” (S50[LD]).
- “To care for people at a most vulnerable point in their lives and to show empathy,” (S34[MH]).
- “I am a compassionate person and want to live whereby I am contributing and making positive change,” (S09[MH]).

Career Prospects

Several participants highlighted aspects of nursing as a career had influenced their choice to become a nurse. Some highlighted the fact that nursing was a respected career. S29[MH] suggested that, “[Nursing] is a respected career with many opportunities to work with all different types of people,” and S73[C] stated that a motivation was, “To be respected in society and have a career which gives something back.” Some respondents identified the variety of opportunities that nursing offered. For example, S81[A] wrote about a desire to, “Have a stable career, in an ever changing environment where every day is different,” and S130[A] stated that, “I wanted a career that I could progress and develop different skills, with many opportunities, also that I could travel the world with.” Like a number of other students, S138[A] had worked as a HCA, but saw the opportunity to become a RN as career progression. They stated, “I loved my job as a health care assistant but wanted to further my career and take on more responsibility and learn more about the healthcare profession.”

Previous Experiences

Previous experiences were key influences for many students. A number of these involved either seeing or being involved in the care of family members. For some the very act of being involved in the care was sufficient. S106[A] suggested that, "I wanted to become a nurse as I have previously looked after family members through illness and really enjoyed the caring side of it." Similarly, S30[MH] stated,

> I wanted to become a nurse when a family member got diagnosed with a long term illness. I became curious with my family member's illness and when they spent [time] in hospital I began to help with their care and enjoy looking after my family member.

For others the standard of care they observed was the motivation. S21[MH] suggested that, "I wanted to become a nurse due to personal experiences of family members receiving health care (good and bad) and wanted to be there to support and help patients and their families through difficult times in their lives." Other students had similar experiences. For example,

> The care that nurses gave my [relative] when she had a brain tumour was amazing. As well as aiding her in making a full recovery after her op, they explained things she didn't understand, held her hand when she was scared and made her feel beautiful when she felt ugly. Because of this I got an extra 16 years with my [relative]. It was also a nurse that recognised my [another relative] symptoms for pneumonia where doctors had failed to notice, and saved his life. I have had nothing but good and fantastic experiences with nurses and from a young age these were the people I have always aspired to be. Maybe one-day people will reflect on their care and say the same things about me.
>
> (S82[A])

> I experienced amazing contribution to my [relative] care when she suffered a stroke and I understand when someone else – a total stranger – gives your loved one complete, individual love and care

> and makes a massive difference to how someone ill can feel. That is my wish, to do just that; care and make a difference.
>
> (S111[A])

Work experience was also a factor. For example, students made specific reference to their work experience including working for a charity, a nursery, or as a nursing, healthcare or physiotherapy assistant. Other students had arranged voluntary work, often whist completing relevant level three qualifications. For one student, these level three qualifications were a motivating factor. S29[MH] wrote, "I did an A level in psychology which increased my interest in mental health which led me to choose mental health nursing."

Others were influenced by issues with their own health. For example, S65[C] wrote,

> Due to previous experiences of personal illness and the treatment I received, I can always remember the nursing care over anything else. It made me feel special to have received such care and would like to give that back to other patients.

<u>Finance</u>

Finance was an influencing factor for five respondents with S28[MH] simply stating, "money," as a reason why they wanted to become a nurse. S98[A] wanted, "a job that would pay me enough to live on," and S141[A] wanted, "a well-paid job." S108[A] did not focus on what they would get paid, but on the financial difficulties they would endure during the programme, a hardship they were willing to endure, "if I could only prevent one patient from experiencing the same poor care that my [relative] received, the stress, heartache and financial hardships in doing this degree would be worthwhile."

S127[A] focused on the fact that one attraction to nursing was that the course fees were paid. They stated that,

> Initially I was drawn to the course because the tuition fees are paid by the NHS. I already have a student debt from a previous degree I finished in 2009 and believe I would not of [*sic*] applied to university degree course again as I was put off by the increase in the cost.

Although this response was made before the UK Government announced changes to the NHS Bursary Scheme (DH, 2016a), the significance of the fees being paid for is not lost on this student.

Personal development and fulfilment

This theme recognised the aspect of personal development and fulfilment that were motivating factors for some students. Three students (S15[MH], S20[MH] and S71[C]) wrote of the fact they could not see themselves doing anything else. Several others wrote that nursing was something they had always wanted to do and S114[A] described nursing being, "a dream … and goal for me."

To gain a professional qualification and/or professional knowledge was highlighted by some respondents. S01[MH] stated that they wanted, "To gain a recognised professional qualification," and S11[MH] wrote, "I decided to become a nurse so that I could care as a professional and gain professional knowledge to enable me to nurse people and improve their quality of life." Others, whilst not highlighting the 'professional' aspect of knowledge referred to the knowledge, skills and experience that they hoped to gain. Examples include S103[A] who wanted, "To improve and learn new skills and knowledge through university and practice." S107[A] was motivated by, "Learning the knowledge and experience building to learn what it takes to be a nurse and confident doing it," and wanted to, "Challenge myself to gain a professional degree in an area of care I feel passionate about." With a hint to lifelong learning, S62[C] suggested that, "You are always learning in nursing."

The aspect of being fulfilled by 'giving something back' was another motivating factor. For example, S133[A] wrote, "I believe caring for the old and vulnerable is truly rewarding and gives me the satisfaction of giving back to society," and S99[A] suggested, "by becoming a nurse I feel that I am giving something 'back' and hope that in time I can contribute greatly to someone else's care."

There was a real sense of pride expressed by some respondents; pride in what they were achieving academically and professionally. S120[A] viewed this as a motivating factor and wrote, "The pride and overall enjoyment of being a nurse was a huge factor

in choosing this career." S108[A] felt, "proud that I am a student nurse, no matter how hard it is," and S57[C] stated, "I am the first member of my family to undertake an undergraduate degree. There was also the element of making my family feel proud of academically achieving."

Relatives in the healthcare professions

A number of the students identified the fact that relatives working in healthcare was an influencing factor. For example, S79[A] wrote, "I have always wanted to become a nurse since I was a little girl as my [relative] worked at the hospital," S95[A] stated, "My family members [various relatives identified] are all carers so this is also normal to me," and S147[A] suggested, "As my [relative] is also a nurse I was aware of the hardships and stress that came with nursing but also witnessed the great satisfaction and sense of purpose she got from her career."

5.8 Qualitative data: Student questionnaire (Question 31)

Question 31 asked the respondents to 'Please write about what you think is the role of the qualified nurse in your particular field of nursing'.

Of the 150 participants, fourteen (9%) did not provide a response to this question. Across the remaining 136 responses, the terms 'advocate' 'advocacy' or 'advocating' appeared in 58 (39%). There was some difference in the distribution of this term across the fields with 32% of Mental Health students, 35% of Adult students, 41% of Learning Disability students and 63% of Child field students highlighting advocacy as an important aspect of the RN's role.

5.8.1 Phase one analysis

What became apparent very quickly was the large number of different ways that similar aspects of the caring role, and the different attributes that seemingly were expected of the nurse were expressed. However, providing care to an individual, family or community was at the heart of many of the responses. There were some concerns expressed regarding the amount of paperwork that RNs were required to complete, to the detriment of this caring role. Some respondents felt strongly that the nurse should be involved directly in the care delivery as well as providing a care co-ordination role through leadership, decision-making and good inter-professional working. The use of evidence base to underpin practice was also discussed as was the need for the nurse to 'keep up to date' through on-going personal and professional development.

5.8.2 Development of codes and themes: Student questionnaire, Q31

Phase two identified the themes highlighted in Figure 5.11. 87 different codes were identified. Progression through phase three facilitated the consideration of synonyms to reduce the number of codes to 67. These were then further refined using the definitions for the 'six Cs' from the Department of Health and NHS Commissioning Board (2012). The list below highlights which codes were subsumed by the relevant 'C'.

<u>Care</u>

Holistic, maintain or improve quality of life, meet needs, protect, provide care, provide patient/family/client centred care, provide personal cares.

24/7 care
A special personality
Ability to desensitize/cope
Advisor
Advocate
Apply knowledge
Approachable
Assertive
Assess/manage risk
Be at bedside
Be caring
Be responsible
Be there
Challenge other HCPs
Clinical skills
Collaborative working
Comfort
Committed
Communication
Compassionate
Competent
Confident
Co-ordinator
Courage
Critical thinking
Decision-maker
Delegate
Dignity and respect
Educating patients
Educating students
Empathy
Encourage
Equality
Field specific
Friend
Give time
Good/expert knowledge and understanding
Hard working
Health promotion
Help and support
Holistic
Honest
Hygienic
Improve the healthcare system
Know their limits
Leadership
Listen
Love what they do
Maintain/improve quality of life
Manage day to day living
Media view
Medications
Meet needs
Never read from a book
Non-judgemental
Offer reassurance
Open to critique
Paperwork
Patience
Personal and professional development
Practice ethically
Problem-solving
Professional
Promote understanding and awareness
Protect
Provide care
Provide guidance
Promote individualised patient/family/client care
Provide information
Provide personal cares
Provide social support
Provide specialist care
Provide therapeutic interventions
Rehabilitation
Respect the view of others
Safe-guarding
Signposting
Speak out about bad practice
The 'six Cs'
The care setting
Therapeutic relationship
Thick-skinned
To be generally awesome
Understanding the value of nursing
Undertake assessments
Use of evidence base
Varied role

Figure 5.11: Phase two identification of initial codes (student questionnaire, Q31)

Compassion

Comfort, dignity and respect, empathy, empower, encourage, give time, help and support, non-judgemental, offer reassurance, therapeutic relationship.

Competence

Assess and manage risk, clinical skills, medications, practice ethically, provide therapeutic interventions, provide social support, provide specialist care, undertake assessments.

Communication

Advisor, educate patients, listen, provide information, respect the view of others.

Courage

Challenge other HCPs, confident, speak out about bad practice.

Commitment

Improve the healthcare system, love what they do, understand the value of nursing.

- Care co-ordination
  - Decision-maker (3)
  - Leadership (8)
  - Paperwork (11)
  - Problem-solving (2)
- Miscellaneous
  - Field specific information (21)
  - Media view (1)
  - Varied role (11)
- Personal attributes
  - Caring (17)
  - Committed (3)
  - Compassionate (13)
  - Courageous (3)
  - Be Patient (2)
  - Thick-skinned (1)
- The professional and the graduate?
  - Be Professional (7)
  - Critical thinking and clinical reasoning (2)
  - Educate students (1)
  - Expert or good knowledge base (18)
  - Know their limits (7)
  - Personal and professional development (26)
- The therapeutic relationship
  - Advocate (59)
  - Health promotion (15)
  - Inter-professional working (38)
  - Safe-guarding (5)
  - The ‘six Cs’ (8)
    - Care (164)
    - Commitment (10)
    - Communication (62)
    - Compassion (110)
    - Competence (92)
    - Courage (15)
  - The care setting (7)

Figure 5.12: Themes and sub-themes (student questionnaire, Q31)

The themes and sub-themes identified during phases four and five are shown in Figure 5.12. The figures shown in brackets refer to the number of references to each sub-theme across the student responses to Q31.

5.8.3 Further details of themes

Care co-ordination

This theme identified the leadership role that RNs will often fulfil as the organiser and co-ordinator of care. As S74[A] suggested RNs should, "delegate and organise care with various professionals." S38[LD] identified a broader perspective on this when they listed that the RN's role was,

> To coordinate services for people with learning disabilities.
> To speak up for their health and social requirements.
> Also to inform other professionals, carers about disorders and syndromes to ensure the service user is receiving the correct treatment.

Decision-making and problem solving skills also featured in the responses.

Personal attributes

As with the Q30 above, respondents used terms like caring, compassionate and committed to refer to both the attribute and the action. Careful reading of each extract identified in which context the individual student was writing. This theme refers to those identified as personal attributes expected of the RN.

The 'six Cs' featured with caring, committed, compassionate and courageous identified as distinct attributes. Caring and compassionate appeared almost synonymously in some replies. For example, S81[A] wrote, "Be caring and compassionate," S99[A], "[Be] kind, caring and compassionate," and S60[C] suggested that an aspect of the RNs role was to be, "caring and compassionate." One student (S20[MH]) when citing 'compassion' as an attribute added, "don't do a job if you don't want to be there and your heart isn't all in it."

Two students (S08[MH] and S82[A]) suggested that the RN needed to be 'patient' and S74[A] stated that they felt an attribute was to be, "Thick skinned, able to cope with

[being] verbally abused though able to be compassionate." This statement would suggest that this particular student had witnessed RNs being verbally abused by patients/service users, although no further information or context was supplied.

The Professional and the Graduate

This theme highlights some of the attributes that were considered in Chapter three regarding professionalism and graduate status. The questionnaire was completed after the students had been on the course around eighteen months. Their experiences in working with RNs during clinical placements would have had an influence on some. No data was collected as to the academic qualifications of the students' mentors or the other RNs they worked alongside. According to the Health and Social Care Information Centre (HSCIC, 2016), in January 2016, the NHS employed 318,640 qualified nurses and health visitors in England but it is difficult to quantify how many of these were graduates. Nonetheless, it is significant that some students highlighted what could be considered as graduate attributes. In other words, there was an expectation that RNs nowadays needed to be critical thinkers and utilise a sound knowledge base supported by current and reliable evidence. S108[A] suggested that RNs needed to, "question everything, and look for new ways of working, so that they can continue to improve their practice." S125[A] wrote that RNs should, "independently think about what is asked of you and not blindly follow orders." This hints at aspects of critical thinking and clinical reasoning. Similarly, S98[A] suggested that the role, "involves an integration of knowledge, caring intentions and problem solving skills."

A good knowledge base was highlighted by several respondents with some, such as S87[A] acknowledging the importance of the use of current evidence. They wrote, "Understand current and relevant research to be able to provide a varied knowledge base and keep up to date with best practice." S80[A] suggested that the role involved, "*Developing and progressing* knowledge to provide the best care for patients," [emphasis added].

S82[A] suggested that the RN should, "Act well and professional at all times as well as under pressure," and S99[A], "provide professional patient-centred care to

individuals." Other students highlighted the need to, "follow NMC code at all times," (S99[A]) or "follow local policies/trust policies," (S132[A]).

The therapeutic relationship

This theme was by far the largest in terms of references. This highlights the significance that the students place on this aspect of the RNs role. The RCN's (2014) definition of nursing used in this study highlights in its characteristics the importance of working in partnership with patients/service users, relatives and other carers and recognises the role that nurses undertake in advocacy, personal cares, therapeutic interventions, physical and emotional support and teaching. S66[C] suggested that part of the RNs role was, "Taking time to get to know patients in order to understand what is and what isn't best for them." As discussed above, many participants across all four fields highlighted the 'advocacy' role of the RN. For example, S26[MH] suggested that, "In mental health the nurse must act as an advocate between patient and many other agencies." S95[A] wrote, "Nurses are advocates for the patient and should ensure patients are treated the best they can be."

The importance of good inter-professional working was recognised. S12[MH] suggested, "Mental health nurses must have an ability to work inter-professionally, therefore an understanding of other professional roles, and service delivery is essential." S57[C] suggested, "Nurses also work inter-professionally in order to meet the needs of the patient," and S84[A] stated, "The role of the qualified nurse in adult nursing is to work inter-professionally within the team."

Predictably, the 'six Cs', collectively and individually, were prevalent across the responses. There were many examples of quotes from students that could have been included to illustrate the significance of the 'six Cs' for them. Figure 5.13 highlights a selection of quotes representing each 'C'.

Some recognised the importance of health promotion as part of the RNs role. S59[C] suggested that nurses should, "work with families and do health promotion," S140[A] identified the, "goals of improving and promoting health of people," and S149[A] wrote that one aspect of the role was to, "Promote healthy lifestyle behaviours."

Care
"To care and support service users and help them to manage their mental health" (S30[MH]).
"Within my field, a qualified nurse should meet the care of service users" (S47[LD]).
"[Provide] emotional and physical care and support" (S57[C]).
"Care from a holistic approach. Patients 'ARE NOT' an illness in a bed whatever! They are people first" (S132[A], original emphasis)

S87[A] acknowledged the wider implications of the therapeutic relationship and suggested that part of the RNs role was, "Dealing with wider issues e.g. social circumstances having the time to fully understand the patients and their specific needs of you at the point of intervention and beyond." S96[A] stated, "I do not believe any part of patient care should be classed as 'not nurses job' all important for assessing patients." S93[A] offered a different perspective, "I expect that nurses ultimately help care for people, however in busy settings this is not the case. Instead the role of care is handed down to the health care assistants and instead I feel there is greater emphasis on the documentation side of things – which is very wrong."

Communication
"MHN [Mental Health Nursing] is massively reliant on outstanding communication skills due to the nature of the many different people and behaviours we come in contact with" (S4[MH]).
"Communication skills form a basis of good mental health care" (S12[MH]).
"Inform other professionals, carers about disorders and syndromes to ensure the service user is receiving the correct treatment." (S38[LD])
"Communication is very important!" (S62[C])
"To communicate with patients and listen to their views" (S103[A])
"Speaking to service user and other professions" (S114[A]).

Within this sub-theme was the idea that communicating with patients was also referred to as advising, teaching/educating, listening, and being a resource.

Courage
"The confidence and courage to question bad practice should be a consideration for all qualified nurses" (S12[MH]).
"To speak up for their [the patient's] health and social requirements." (S38[LD])
"Courageous" (S66[C])
"Able to speak up if they think somebody has made a mistake." (S74[A]).
"Willing to stand up for what they think is right and in the best interest of their patient." (S98[A]).

Compassion
"To act with compassion." (S12[MH]).
"Be compassionate." (S47[LD]).
"Support patients when they do not understand what is happening – be the person they can trust" (S55[C]).
"To provide care, compassion and support psychologically as well as physiologically" (S143[A]).

Competence
"To provide treatments i.e. medications etc. Monitoring for side effects and signs of improvement/deterioration within the service user's health" (S29[MH]).
"Nurses are responsible for carrying out important observations as well as providing medications" (S57[C]).
"It is about providing clinical skills required for that individual person" (S87[A]).
"In acute settings it is the role of the nurse to structure assessment in an ABCDE approach" (S94A)
Within this sub-theme there were also several references to medicines management.

Commitment
"Working hard and always being committed to making a difference" (S66[C]).
"Be aware of societal changes and the implications for the nursing/health profession" (S108[A]).
For those working within the National Health Service, S107[A] highlighted a commitment to the organisation suggesting nurses should, "Represent the NHS with the core values and own moral being."

Figure 5.13 Selected references to 'the 6C's'

5.9 Qualitative data: Nurse educator questionnaire (Question 21)

Question 21 asked respondents to 'Please add your own views on the move to all graduate entry to nursing'. Eighteen of the twenty respondents (90%) provided a free text response to this question, representing all four fields of nursing. Respondents are identified by the prefix N to distinguish them as nurse educators. This is followed by a number randomly allocated between 01 and 20, followed by an abbreviation of their field of nursing as used for the students.

5.9.1 Phase one analysis

The move to an all graduate entry to nursing was generally supported, with many recognising the complexities of healthcare in the twenty-first century. There was a recognition amongst some respondents that academic ability and attributes such as being caring and compassionate were not mutually exclusive. Others expressed some concerns that mature students and other potential applicants to nursing would be prevented from applying due to the increased entry requirements and academic level. There was a hint of a philosophical approach from some, suggesting that if potential applicants really did want to nurse, they would overcome these obstacles. Other respondents offered an alternative, suggesting that there were other roles within healthcare that those unable to fulfil the requirements for undergraduate nursing could undertake.

5.9.2 Development of codes and themes: Nurse educator questionnaire, Q21

The initial codes generated during phase two are shown in Figure 5.14.

A seat at the top table
Academic ability and attributes
Complex nature of healthcare
Critical thinking and clinical reasoning
It is all about the course
Leadership
Mature students
One size does not fit all
Other healthcare opportunities
Personal and professional development
Professional
Vocation
Welcomed

Figure 5.14: Phase two initial codes (nurse educator questionnaire, Q21)

The themes and sub-themes identified during phases three to five are shown in Figure 5.15. The figures in brackets represent the number of references per sub-theme across the questionnaire.

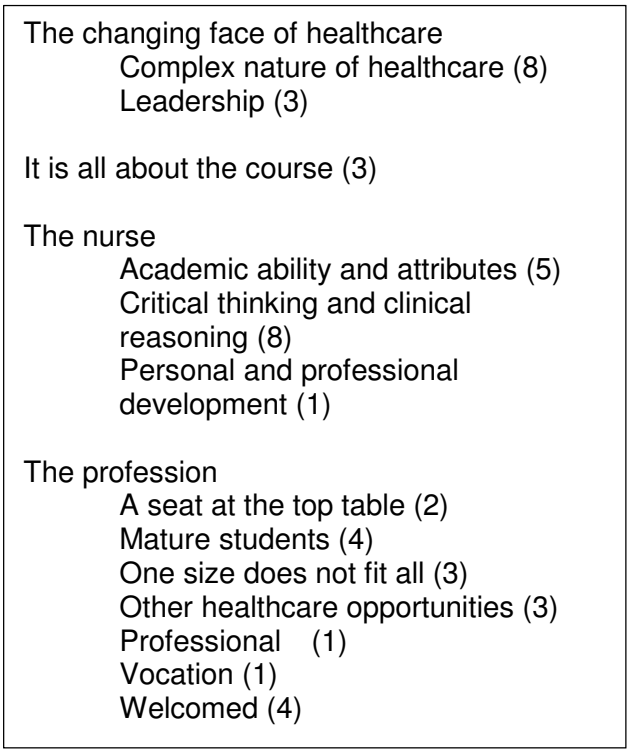

Figure 5.15: Themes and sub-themes for nurse educator questionnaire, Q21

5.9.3 Further details of themes

It is all about the course

This theme focused on the comments that three respondents made in relation to the design of the programme itself. N04[A] suggested that,

> The nurse will be as good as the course prepares them for and this is also dependent upon the quality of the experience offered and what the student is prepared to put into it, no matter what level of the course.

N11[MH] focused on the balance between theory and practice and suggested, "Many people do not appear to appreciate the amount of time spent by students in the practice setting and the role this has in their overall learning (both positive and negative)." N08[A] focused on recruitment to the course and suggested, "It is important that recruitment of nurses onto the course takes account of not only

academic ability but of the qualities that nurses should possess - such as professionalism, motivation, enthusiasm, compassion and commitment."

The changing face of healthcare

Respondents commented on the impact of the complex nature of healthcare in the twenty-first century. N04[A] suggested, "as a qualified nurse taking on responsibilities that are inclusive of some former medical and higher managerial roles requires this person to have a much more complex range of knowledge and abilities, which a degree will prepare them for." N07[A] referred to the ever-changing nature of healthcare; "This move is required to develop nurses who can problem solve and deliver care that is complex in an environment that is constantly changing both at practice level and a political level." N05[A] wrote,

> The move to all graduate training is about the nurse being able to function autonomously in a high tech environment and having the ability to be able to make decisions that influence, guide and support the appropriate decisions of patients where required.

N09[A] discussed nurses being better equipped to respond to on-going demographic and social changes,

> The UK, like most of the developed world, is witnessing an increase in an ageing population. This phenomenon has the tendency to carry with it people with long term conditions or diseases which are often intractable and chronic in nature. The nursing profession needs to respond to this demographic and social trend and educate pre-registration nurses to graduate level to tackle the multi-layered complexity of nursing and medical care.

Leadership was also discussed. N06[C] suggested, "The role of the nurse in modern healthcare is complex. Nurses are often leading and managing care and need high order skills to do this." N14[LD] suggested, "We [Nursing] need strong knowledgeable nurse leaders. The degree is a starting point," and N15[C] wrote, "Nurses without critical thinking and leadership abilities will flounder in the face of the pressures on the NHS and this will impact on patient care."

The Nurse

This theme focused on the attributes required by the individual nurse. Some respondents discussed the balance between personal attributes such as being caring and compassionate, and academic ability. For example, N09[A] suggested, “A degree may never generate caring and compassionate nurses, but, I would argue, that degree status will enable them to become aware of such important values in the caring process.” N10[A] stated, “Nursing is a multi-faceted profession where academic creditability, caring and compassion do not need to be mutually exclusive,” and N15[C] wrote, “Whilst I do not believe that having a degree is the only quality that makes a good nurse, I think all nurses should have a high level of knowledge and be skilled to undertake the role in the current climate.”

Several respondents focused on the issue of critical thinking. N01[LD] suggested, “Going to graduate level is not about gaining a degree to me it’s about getting people who can think through the complex issues that nursing creates.” N19[A] felt that, “Having developed critical analysis skills and the ability to engage in critical discussions nurses will be better able to engage with decision making with and on behalf of patients within the interdisciplinary team.”

Finally, N08[A] referred to the on-going professional development of the nurse and stated that the move to an all graduate entry will, “encourage nurses to be independent learners and hopefully for them to take responsibility for keeping up to date with their CPD [continuous professional development] which I believe is paramount for a nurse to do.”

The Profession

The final theme highlighted the perceived impact on the nursing profession as a whole. The move was generally welcomed. N01[LD] felt that, “moving to degree level is excellent for nursing,” N02[A] wrote, “This move can only result in benefits to the profession and to patients,” and N16[LD] saw the move as, “An essential requirement for the future of nursing - essential for delivering high quality care meeting the expectations of all sections of society.” N09[A] discussed a caveat to their endorsement of the move suggesting, “from an academic and caring perspective, I

highly welcome an all graduate status for the nursing profession providing patient care is demonstrably improved with recourse to evidence-based practice regardless of where care is located." However, some concerns were expressed. N04[A] suggested,

> My feelings are that nursing needs differing levels of knowledge and that there is room for nurses with and without degrees … I do feel that an all degree profession will exclude the mature nurses that have not got the relevant qualifications in some circumstances.

N01[LD] also discussed the plight of 'mature students', "I however do feel that steps have to be taken to ensure that mature students without qualifications are encouraged to step up to the required level and a good mix between intellect and skill is essential."

Two respondents provided a different perspective on this issue. N10[A] suggested, "Nursing is a vocation and anyone who truly wants to be a nurse will go and gain the qualifications required for entry," and N12[A] acknowledged that,

> Yes, some non-academic capable individuals that would make excellent nurses will be excluded however they can still have an important part to play in the delivery of care through HCA status for example. I also think we have to consider that by having all graduate entry we will attract people with excellent potential that may never have applied if we did not have all degree entry status – 'swings and roundabouts.'

N08[A] suggested that the move would, "provide the recognition on a par with the other allied health professionals," and N12[A] felt that the move was required, "if we are to 'professionalise' nursing and help develop its status as an independent professional body of experts."

5.10 Qualitative data: Allied Health Professional (AHP) educator questionnaire (Question 21)

Question 21 asked respondents to 'Please add your own views on the move to all graduate entry to nursing'. Eleven of the fifteen respondents (73%) provided a free text response. Respondents represented all the additional health professional courses taught within the School, midwifery (Mid), occupational therapy (OT), operating department practice (ODP), physiotherapy (Physio) and podiatry (Pod). The respondents are identified as Allied Health Professional Lecturers by the prefix AHP, followed by a randomly generated number between 01 and 15 and an abbreviation of their health professional qualification as shown above.

5.10.1 Phase one analysis

First impressions indicated that many of the respondents were supportive of the move to an all graduate entry to nursing, citing equality with other healthcare professions, and the need for a nursing workforce with improved critical thinking and clinical reasoning skills. As with the nurse educators, the changing nature of healthcare in the twenty-first century also featured. Concerns were expressed by one respondent (AHP8 [ODP]) that the move to an all graduate entry would not, in itself, improve the standards of care delivered to patients, although no further rationale or evidence was given to support this. Two other respondents, both representing podiatry (AHP1[Pod] and AHP15[Pod]) expressed serious concerns about the actual academic level and standards of the Nursing degree programme and how a 'dumbing down' of standards may influence recruitment for other graduate programmes.

5.10.2 Development of codes and themes: AHP educator questionnaire, Q21

Reading through the responses, it became clear that many of the themes from the nurse educators were repeated here. Therefore, the same codes/themes were used as a starting point, with more added if required to represent the data. No additional codes were generated. The number of references for each theme and sub-theme for the AHP educator questionnaire are shown in Figure 5.16.

The changing face of healthcare
- Complex nature of healthcare (2)
- Leadership (0)

It is all about the course (2)

The nurse
- Academic ability and attributes (2)
- Critical thinking and clinical reasoning (3)
- Personal and professional development (0)

The profession
- A seat at the top table (4)
- Mature students (3)
- One size does not fit all (1)
- Other healthcare opportunities (0)
- Professional (0)
- Vocation (1)
- Welcomed (4)

Figure 5.16: Themes and sub-themes (AHP educator questionnaire, Q21)

5.10.3 Further details of themes

It is all about the course

Two respondents, both from podiatry wrote about their concerns regarding the academic level of the nursing degree and how this would impact on other graduate courses. Although lengthy, these extracts are included in their entirety. AHP1[Pod] stated,

> The scope and rigour of the course are more important than the name. Although I am not a nurse, I have heard anecdotally from many sources that the rigour of a nursing degree is no greater than that of the former diploma course, and may be lower in some cases. Correspondingly the quality of recent nursing graduates is perceived to be no better, or actually worse, than former diploma qualified nurses on the whole. I also think that giving vocational qualifications such as nursing degree level status is likely to have implications for the take-up of subjects more traditionally associated with degree level qualifications, such as, for example, physics and engineering. If a course which formerly was considered to be worthy of a diploma is now worth a degree, with no obvious improvement in the quality of

> graduates, why should anyone be prepared to work harder for a degree in, say, Physics, which is not being offered at the level of a diploma? Inevitably this will lead to grade inflation and a dumbing down of traditional degree level courses to avoid losing numbers to courses such as nursing, where it may be perceived that it is possible to get a degree on the cheap, so to speak, academically.

AHP15[Pod] wrote,

> Totally unconvinced that the academic standard required to obtain a degree in nursing is (a) any higher than the standard to obtain a corresponding diploma; (b) equivalent to the standard required to obtain a degree in many other subjects. My concern is that inevitably this will mean a dumbing-down in what is considered an appropriate level of education for a graduate to have achieved.

<u>The changing face of healthcare</u>

One respondent (AHP11[OT]) commented on the increasing complexity of nursing and suggested that they were comparable with other AHPs. They wrote, "I believe that the complexities of nursing are comparable with the skills required in other professions and therefore the graduate programme will increase acknowledgement of this." AHP12[Physio] suggested that the public may perceive the move to be the result of changes in doctors' working. They suggested that,

> The public's perceptions may not be great especially with all the changes in the NHS at the moment. The change may be perceived to be in response to decreasing doctors' hours and roles and having graduate nurses take their jobs.

<u>The nurse</u>

Two AHP educators offered responses similar to those from the nurse educators in relation to the debate between academic achievement and personal attributes, and their impact on care provision.

> I do not believe that having a degree makes a person compassionate or caring. Neither do I believe that having a degree prevents a person from being compassionate or caring. Being a nurse (or midwife etc.)

> requires the ability to use sound and critical knowledge to support and enable the people we are caring for to achieve the best possible outcome in an empathetic and compassionate way.
>
> (AHP13[Mid]).

> I remain unconvinced that the move to a graduate level will, in itself, improve the care afforded to patients on a daily basis. Much direct care appears to be undertaken by care assistant type grades and I share the concerns of others that nursing may find itself pursuing the academic route to specialisation and leave behind the 'traditional' role of caring for patients on a direct & daily basis.
>
> (AHP08[ODP])

AHP03[Physio] offered a personal perspective on the issue of the fundamentals of care being transferred to other healthcare staff. They wrote,

> In terms of 'qualified' nurses leaving the work to less qualified staff, from my own experience as a patient, this already happens in some wards and is independent of degree status and is perhaps more to do with attitudes and lack of vocation in some individuals.

Developments in critical thinking and clinical reasoning were seen by some as positive outcomes from the move. AHP03[Physio] suggested, "It is important that nurses gain the academic skills afforded by undertaking a degree which will enable them to evaluate practice and the evidence base for treatments." AHP13[Mid] stated that, "One of the aims of having an all graduate profession is to enable practitioners to be more critical of their roles and responsibilities and the evidence on which they base their decisions about practice." They pointed to an increased litigious culture surrounding healthcare before concluding,

> Having the ability to provide a sound rationale for an act or omission, rather than referring to common practices, is increasingly more important … having a sound and critical understanding of these and the ability to challenge in a professional and educated way is important in maintaining vital nursing values as well as ensuring that the correct medical procedures are carried out.

The Profession

Reaction to the move was generally positive amongst this group of AHPs. AHP09[Mid] suggested, “In the current climate and context it is important that there is graduate entry to nursing,” AHP11[OT] saw the move as, “a much needed step forward for the profession,” and AHP12[Physio] felt the move was, “excellent.” The rationale for those citing some opposition has already been presented in different themes above. Significantly, more AHP respondents than nurse educators highlighted that the move would bring parity to nursing with the other allied health professions. AHP05[OT] wrote,

> All graduate entry will bring nursing into line with other professions, like my own, that have gone through a similar progression. This parity is vital in terms of the perception of the profession by other professions, the public and nurses themselves.

AHP07[Physio] felt the move was, “necessary really given that other health professions courses are degree level courses,” and AHP11[OT] wrote,

> This move will assist in aligning nurses with AHPs as I believe that the complexities of nursing are comparable with the skills required in other professions and therefore the graduate programme will increase acknowledgement of this.

AHP03[Physio] felt that, “Parity with the other degree health care professions is important for their MDT interactions, sharing their EBP [evidence-based practice].”

Similar to the nurse educators, there were some concerns expressed that the move may prevent some potential nurses from applying. AHP14[Mid] wrote, “I was an excellent nurse and midwife, but I would not have been accepted onto a graduate programme with 6 O-levels and no A-levels! I worry that potentially excellent nurses and midwives will be excluded.” APH07[Physio] stated that, “I do have concerns that there are some candidates, particularly mature students, who will find it harder to enter the professions as a degree course,” though added as a caveat that their perception may be altered due to their involvement at the time on the health profession foundation degree.

5.11 Bringing it all together

The data obtained and analysed has met the aim and objectives for this study as presented in Chapter 4. Educators who did respond were clear and unequivocal in their attitudes towards an all graduate entry to nursing. The nurse educator focus group provided clear indication of the participants' attitudes towards the move and their experiences in teaching and supporting students through the first two years of the programme. The student questionnaire provided comprehensive data on their motivations for staring the programme, and what they perceived the role of the RN in their field to be. Finally, the student focus group provided much data on the participants' experiences on the programme, not least a robust critique of the standards of care observed whilst on clinical placement.

However, the data obtained could be criticised as being disparate, with each data set being distinct in its objectives and outcomes. Whilst there is clearly an element of truth to this, I reasoned that attempts needed to be made to provide some coherence between the many different themes. In devising this overarching list of themes, it was recognised that they could not and would not be 'all encompassing', nor would they, in their totality, address the objectives of the study, which, as argued above, had been met. The objective was to create a unified summary of the themes across the whole data corpus. These overall themes are presented in Figure 5.17.

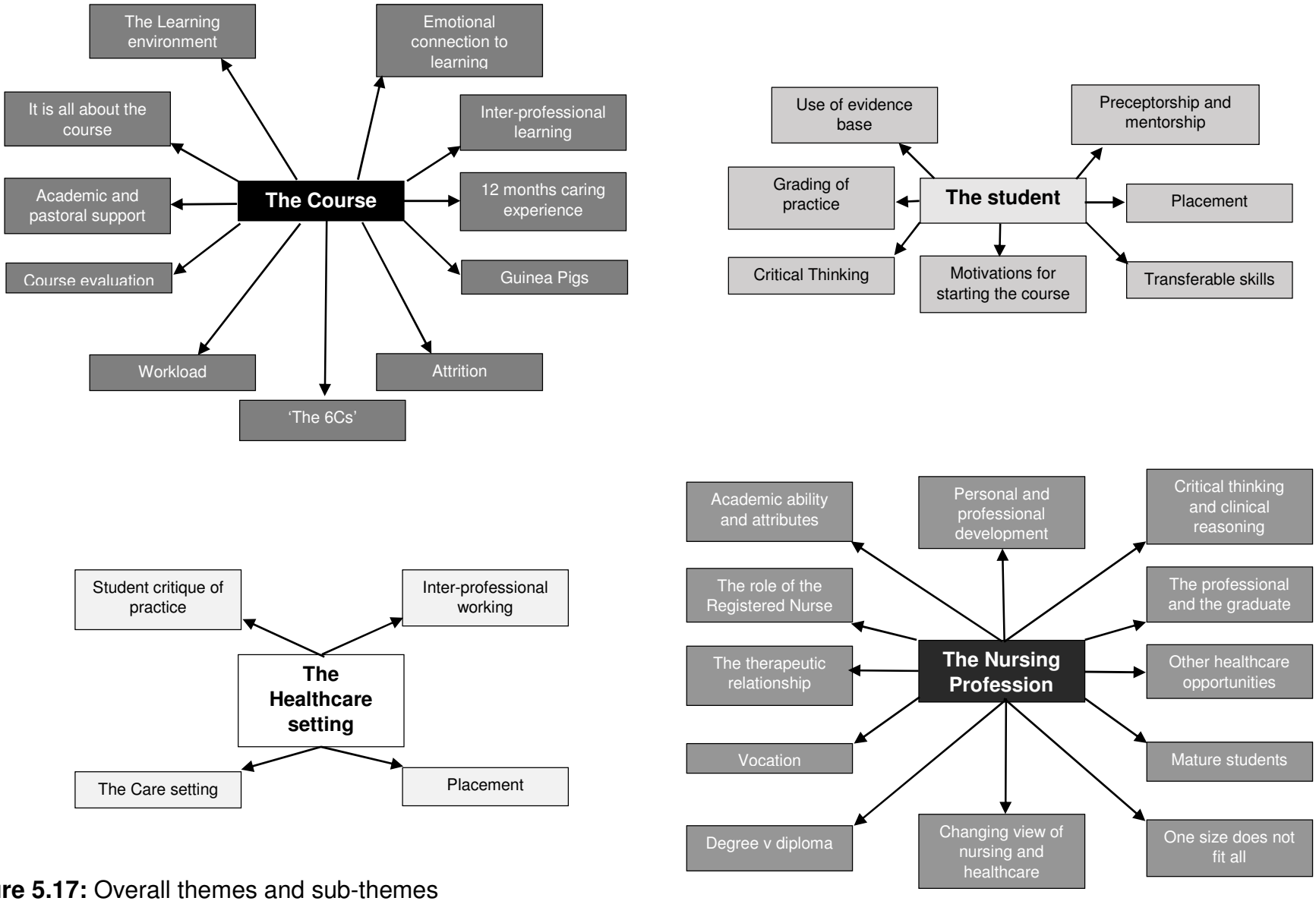

Figure 5.17: Overall themes and sub-themes

Chapter 6: Discussion: An all graduate entry to nursing

6.1 Introduction

This study utilised a range of methods and sources to obtain data linked to the research question and aim. This produced extensive data, leading to detailed analysis presented in Chapter five. Qualitative themes within and across the data sets were generated and descriptive statistics presented. The aim of this chapter is to bring these themes and statistics together in a cohesive way in response to the research aim, critically examining student nurses' and healthcare educators' perceptions and experiences of all graduate entry to nursing in one University in England. To recap, the specific objectives for the study were to:

1. Critically investigate the attitudes and experiences of health educators in relation to an all graduate entry to nursing.
2. Critically examine the motivations of students for starting the programme and their expectations of the role of the qualified nurse from their field of nursing.
3. Critically evaluate the experiences of students undertaking the programme using a focus group based at the University.

To facilitate this process, the conceptual framework presented in Chapter three and shown again in Figure 6.1 will be utilised.

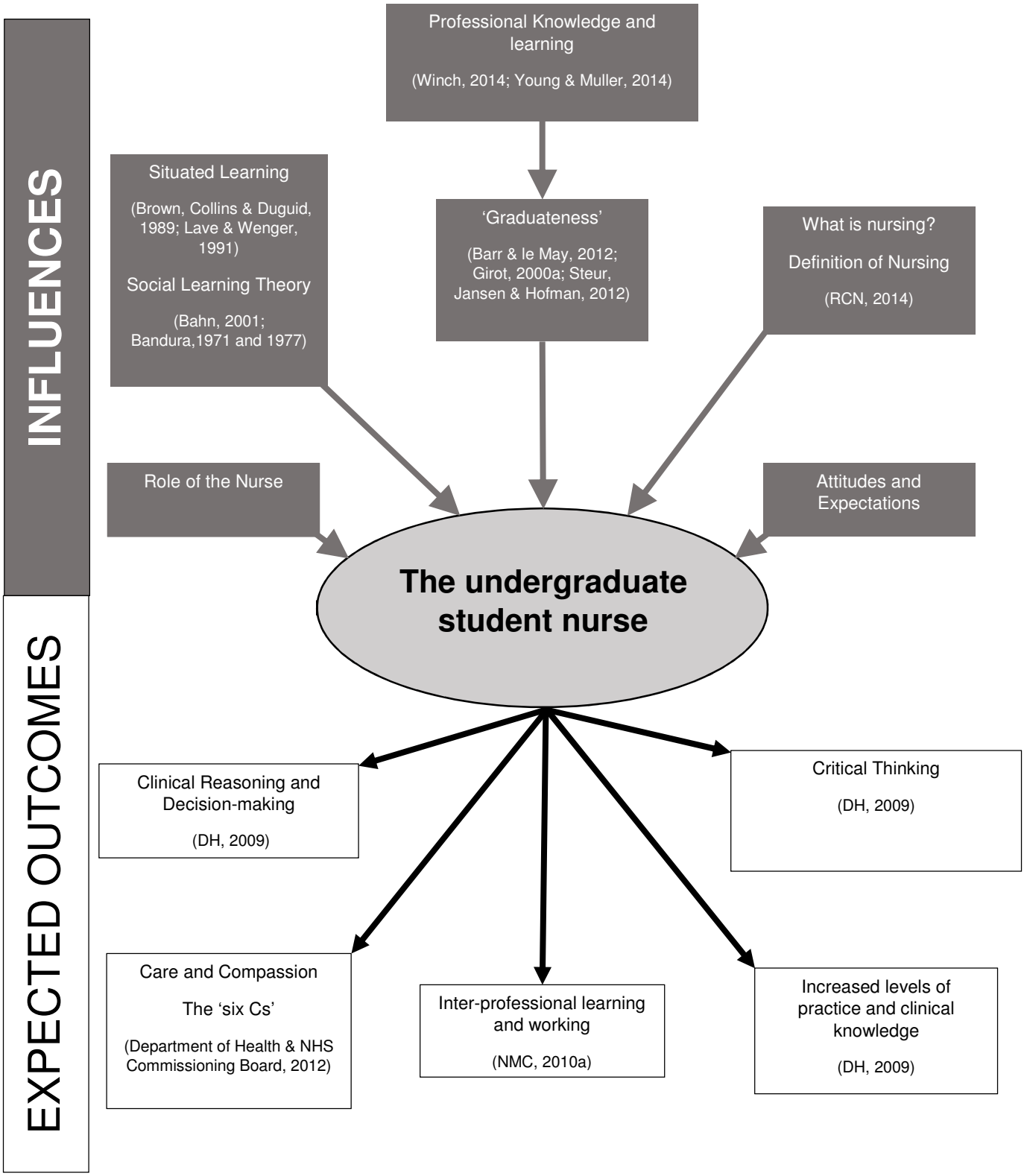

Figure 6.1: Conceptual framework – All graduate entry to nursing

6.2 Influences

The conceptual framework includes a number of key influences on the development of the undergraduate student nurse and was designed before the analysis of data, but all of the influences were either directly referred to in or derived from the data.

6.2.1 Attitudes and expectations

The questionnaire distributed to the nursing students in this study was modified from one used by Toth *et al*. (1998). Toth *et al.* (1998) set out to investigate if there were any differences in attitude towards nursing between traditional nursing students and second degree students. Mean ages were 23.3 years for the traditional students and 30.0 years for the second degree students with an overall mean age of 25.1 years, (SD: 7.1). This compares with a mean age of 24.6 years (SD: 6.7) for the current study, where students completed the questionnaire eighteen months into their undergraduate programme.

A review of the upper scores identified a remarkable similarity between the study by Toth *et al.* (1998) and the current study. In both studies, the highest mean score was for 'statement 8', a recognition that the service given by nurses is as important as that given by doctors. Participants from both studies also identified nursing as exciting ('statement 20'). Toth *et* al (1998) confirm that all 388 of their participants either 'strongly agreed' or 'agreed' with 'statement 1', 'Nurses are patient's advocates'. In the current study, 146 of the 150 participants (97%) either 'strongly agreed' or 'agreed' with this statement. Of the remaining four participants, two were 'neutral' (one adult and one mental health field) and two, both from the adult field, 'disagreed'.

Bolan and Grainger (2009) report on a longitudinal study in Canada investigating whether or not nursing students' perceptions of nursing changed during their programme. The students were all on a baccalaureate programme spread over three sites in one Canadian province. The Nursing Attitude Questionnaire (Toth *et al.*, 1998) was used alongside the Nursing Orientation Tool devised by Vanhanen and Janhonen (2000, cited in Bolan & Grainger, 2009). The mean age for students at graduation (after a four-year programme) was 24 years. Bolan and Granger (2009) noted a significantly more positive perception of nursing as the students progressed through

the programme. Unfortunately, direct comparison of mean scores is not possible, as the studies by Toth *et al*. (1998) and Bolan and Grainger (2009), both used 30 statements and seven items were re-coded during analysis – no details are given as to which these items were and how they were re-coded. However, the current study still reflects a positive view to nursing similar to that from the participants in the studies by Toth *et al.* (1998) and Bolan and Grainger (2009). In the current study, participants 'disagreed' with 'statement 17' (Mean: 2.02; SD: 0.85) that doctor's orders are followed without question. Participants also recognised that nurses seeking higher degrees are not frustrated doctors ('statement 19', mean: 2.13; SD: 0.82). The responses would suggest that these nurses are therefore participating in the continued development of nursing as a profession ('statement 26', mean: 3.26; SD: 1.01). Contrary to the study by Brodie *et al.* (2004, p.730), the participants in the current study appeared not to view nursing as, "a subordinate profession, requiring only common sense and little intellectual capacity."

Brodie *et al.*'s (2004) study involving predominately diploma nursing students and recently qualified Registered Nurses (RNs) from two English universities found that the students' clinical placements permitted them first-hand experience of the realities of nursing, plagued, they argued by chronic staff shortages and low morale. This, and a disparity between the 'ideal' taught in university and the 'real' seen in clinical practice, resulted in a change in perception of nursing amongst the participants in their study. The focus group participants from the current study referred to the 'ideal' versus 'real' paradigm as a significant frustration and also referred to the poor standards of care and attitudes of some staff that they worked alongside in clinical practice. Price, Hall, Angus and Peter (2013) identified that, "timing is an essential component of narrative configuration," (p.312). They reflected that participants in their study provided a narrative account of reasons for choosing a career in nursing soon after commencing the programme, so had just undergone a period of 'selling themselves'. For the current study, the questionnaire was completed part-way through the students' second year and therefore any need to 'sell themselves' was not seen as significant. However, the students had had three periods of clinical placement which may have affected their attitude towards nursing. Whether these perceptions had become increasingly more positive since the start of the course, as with the participants in Bolan and Grainger's

(2009) study, or whether they were affected negatively because of their experiences observing poor standards of care from some RNs is not clear. What was apparent in some responses to the student questionnaire in the current study and amongst the student focus group members was that the observed poor standards of care provided a real motivation to deliver better standards than they had witnessed.

Motivations for choosing a career in nursing

A great deal has been written on the reasons and motivations for nursing students choosing nursing as a career. The motivations identified in this study reflect those identified by several other studies. For her phenomenological based study, Beck (2000) asked 27 nursing students on an undergraduate research course about their reasons for wanting to study nursing. Beck (2000) identified eight themes, which as with the current study, included an intense desire to help others. Other themes identified from the current study resonate with those from Beck (2000), namely the influence of family members in the healthcare professions and the significant influence of observing nurses in action. Beck's (2000) narrative indicates that for her participants these 'observations' were positive experiences, in other words, the care given was of a high standard. This contrasts with the current study where the care observed was not always good. As discussed above, the desire to deliver a higher standard of care than that witnessed was a key motivating factor for some students in the current study. Jirwe and Rudiman (2012) investigated the motivations of student nurses from 26 universities across Sweden. Their study, which began in 2002, was longitudinal and followed students from the beginning of their programme to up to five years after graduation. Two cohorts of students across the different universities (expected to graduate in 2002 and 2004) were involved. Data collection was via self-reporting questionnaires collected using a postal survey and a total of 2847 students consented to participate and completed the baseline questionnaire. There were some variations in terms of age, number of students with an immigrant background, and students with previous healthcare experience between the two cohorts. Overall, nearly 75% of participants expressed a desire to care for and help others as a key reason for choosing to study nursing. Approximately 80% chose nursing because of the wide range of tasks and areas to work that it afforded. Price *et al.* (2013) in a Canadian-based study specifically involving the 'Millennial Generation' (those born

during or after 1980) identified an intrinsic desire to make a difference and help others. Price *et al.* (2013) interviewed twelve women, justifying the sample size with reference to the interpretive nature of the study and the wealth of data obtained from each participant. There is no information on how the twelve participants were selected from the 185 possible participants. None of the twelve participants were male, despite the fact that being male was not an exclusion criteria. For some of Price *et al.'s* (2013) participants, nursing was something they had always wanted to do, with hints from a small minority of a 'calling'. 22% of the participants in Barriball and While's (1996) study (Ireland, n=422) stated that nursing was something they had always wanted to do. Of the remaining 78%, altruistic motivations were a major contributing factor. The motivations presented across these different studies are reflected in the current study. Miers, Rickaby and Pollard (2007) in their study examining career choices and motivations amongst healthcare students studying the four fields of nursing, midwifery, physiotherapy, occupational therapy and diagnostic imaging (radiotherapy) at one United Kingdom (UK) university reported that only students from adult and child nursing expressed a longstanding motivation to nurse. In the current study, sixteen (out of 150) of the student nurses, representing all four fields, stated that nursing was something they had always wanted to do. For the majority of these the desire was to nurse rather than study a particular field. The choice of field came later. Another four students stated a longstanding desire to work in healthcare.

Several participants in Price *et al.'s* (2013) study also discussed nursing as a career that provided guaranteed work and financial security. The student nurses in McCabe, Nowak and Mullen's (2005) Australian-based study in response to the question 'what are you looking for in an occupation?', identified 'working to help others' and 'interesting work' as key factors. As part of their study, McCabe *et al.* (2005) offered some comparison between their 2003 student cohort and data obtained from the 2002 RN Survey during which respondents were asked to indicate the extent to which each of 28 statements was a consideration in their initial decision to pursue a career in nursing. McCabe *et al.* (2005) indicate that these participants had varying lengths of experience, were of varying age, had undertaken various designs and levels of initial training/education, and were responding based on recollections of historical thoughts and initial motivations. Nonetheless, the study reported a, "reasonable consistency,"

(p.390) in responses between those who had just started their nursing education and those who were registered and were reflecting on their motivations. In a comparative study based in the UK using data collected from two pre-registration nursing cohorts (1983: a hospital-based three-year apprentice-style course, and 2005 where information on the academic level of the programme is not supplied, but likely to be diploma), Johnson, Haigh and Yates-Bolton (2007) identified that students in the later cohort valued altruism less at the start of their programme, but generally maintained a consistent view on this throughout the programme. In contrast, students in the 1983 cohort appeared more altruistic at the start of their programme, but this reduced more significantly throughout the rest of the programme. Miers *et al.* (2007) identified that undergraduate students were more likely to identify altruism as a motivating factor than their diploma counterparts. As most nursing students were, at the time, on diploma programmes, the authors suggested that students aspiring to be graduates who possessed a strong motivation to care were choosing professions other than nursing. The move to an all graduate entry will provide more opportunities for aspiring graduates to choose nursing. As the current study has identified, at least within the context of one UK university, altruism was a key motivating factor and therefore the motivation to want to help others *did* exist within those aspiring graduates who chose nursing.

The second theme identified in the current study regarding the participants' motivations for becoming a nurse was 'personal development and fulfilment.' The 'fulfilment' aspect included several references to the enjoyment gained from helping others. Some felt a need to 'give something back' either to society in general or to nursing in particular, especially in relation to care either they or a family member had received. Nursing was recognised as being a 'challenge' and 'not boring'. Significantly, only two participants, one each from the adult and child fields, referred to a degree programme, one (mental health) referred to a desire to attend university and one (mental health) expressed a desire to gain a professional qualification. Clearly the primary motivation amongst this cohort was not the academic level of the programme. A key outcome from this study, therefore is a recognition that the major motivation for pursuing a career in nursing for the participants in this study is consistent with that identified in other national and international studies spanning the last 30

years. Nursing students want to 'nurse'; they want to help others and make a difference. There are further intrinsic motivations such as giving back to society and a sense of personal fulfilment, but extrinsic factors such as financial rewards and the academic qualification itself had a much lower priority.

Degree/graduate status

According to participants in the student focus group, the fact that they were undergraduate nursing students was not discussed whilst they were in clinical practice. None of their mentors or other staff appeared to change their approach to the students *because* they were undergraduates. Significantly, for one of these participants was her feelings of discomfort being an undergraduate student during early placements. This highlights an expectation in and of herself that she should have known more and been able to do more in clinical practice, when in truth she was an inexperienced practitioner. She hinted that she would have felt more comfortable under the apprentice-style training where the student was employed by the hospital and known to members of staff. She suggested that this offered the student the opportunity to approach their learning with humility. The term 'humility' applied here to nursing links with the vocational, even religious, connections with early nursing and nurse education (Bradshaw, 2013; Davies, 1977). The students reflected a positive attitude towards nursing, and recognised that the therapeutic relationship and 'six Cs' were fundamental to the role of RNs across the fields of nursing. They also demonstrated a motivation that reflected these principles and, to some extent recognised them in themselves. The importance of developing and demonstrating graduate attributes, discussed below, was acknowledged by the students, but these were not seen to be as significant as the fundamental principles of what it means to be a nurse.

Nurse educators

Three of the four nurse educators who participated in the focus group described resistance from colleagues in clinical practice in the aftermath of the decision to move to an all graduate entry. The attitude of these mentors reflected many of the posts on the *Nursing Times* message boards (Bernhauser, 2010; Fleming 2009) used for the questionnaires for nursing and allied health professional (AHP) educators. Analysis of the data indicated that the nurse educators who completed the questionnaire were

generally in favour of the move. AHP educators were, as a group, also in favour of the move, but a little less so than their nursing colleagues.

Free text responses to question 21 of the nurse educator questionnaire invited respondents to add their own views on the move to an all graduate entry to nursing. Responses suggested a generally positive attitude to the move with terms like 'excellent' and 'essential' used. However, there were some caveats around accessibility for mature students to an undergraduate programme, and the requirement for there to be a demonstrable improvement in patient/service user care to justify the move. One respondent (N09[A]) suggested the increased use of evidence-based practice as an indication of improved care, but did not indicate how this should be measured. Improvements (or otherwise) in care will be multifactorial, and will not happen 'overnight'. Studies have demonstrated a significant reduction in mortality with increased numbers of nurses with degrees, in the USA (Aiken *et al.*, 2003), Europe (Aiken *et al.*, 2014), and Qatar (Gkantaras, *et al.* 2016). Care is not exclusively delivered by nurses, but they are, "the backbone of every modern healthcare system," (Gkantaras, *et al.* 2016, p.3042), therefore the outcomes of these studies should not be overlooked.

AHP educators

Question 21 of the questionnaire sent to AHP educators invited participants to add their own views on the move to all graduate entry to nursing. Apart from the responses from two podiatry participants, the comments were positive. There was a clear sense amongst two of the three respondents from podiatry that although the title of the award had changed, the academic standards of the programme and the knowledge and ability of the students had not altered. These accusations necessitate further comment. The programme was/is subject to the same academic standards, scrutiny and quality assurance as other degree programmes across England. In addition, as with all approved pre-registration nursing programmes, the Nursing and Midwifery Council (NMC) validated the programme before it commenced, and undertakes regular revalidations. The only Operating Department Practitioner (ODP) participant to provide a free text response suggested that they remained unconvinced that the move to an all graduate entry to nursing would improve the level of patient care. This

response was written before the decision was taken locally to move Operating Department Practice from diploma to degree level. It would be interesting to gauge this participant's perception on the impact that this change will have in relation to the ODPs ability to 'care' for patients.

There was consensus amongst the four participants in the nurse educator focus group that the move to an all graduate entry was both welcome and needed. All four respondents identified equity with the other AHPs as being significant. 'Statement 3' on the nursing and AHP questionnaire stated 'Nurses, like colleagues in occupational therapy, physiotherapy and radiography should be educated to degree level'. Whilst this statement did not directly refer to 'equity' it is worth noting the mean Likert scale scores for it. The mean score across nurse educators was 4.75 [SD: 0.44] (Adult: 4.75 [SD: 0.45], Child: 4.50 [SD: 0.71], LD: 5.00 [SD: 0], MH: 4.67 [SD: 0.58]) and across AHP academics was 3.67 [SD: 1.50] (Midwifery: 3.67 [SD: 1.53], OT: 4.75 [SD: 0.50], ODP: 3.50 [SD: 2.12], Physiotherapy: 4.00 [SD: 4.00], Podiatry: 2.00 [SD: 1.73]). These scores indicate, as reflected above, that nurse educators had a more positive attitude towards the move than their AHP colleagues. However, it is worth noting that more AHP participants (4/15 [27%]) cited equity with other health professionals in their free text responses than nurse participants (2/20 [10%]). Although the sample was very small, these results do offer an insight into the perceptions of AHP educators to nursing, and nurse educators to the other allied health professions.

6.2.2 Graduateness, the profession and professional knowledge

In many respects, issues around 'graduateness' lie at the heart of the debate on the move to an all graduate entry to nursing. These graduate traits, considered so vital to the role of the nurse by some and superfluous by others, debated in Chapters two and three, were discussed by several participants. There was a recognition by many that these traits were required by RNs working in twenty-first century healthcare. Singled out for particular note were critical thinking and the use of evidence-based practice, including its application in a clinical context, thereby demonstrating an understanding of research. Other traits discussed were the nurse's ability to communicate effectively with other members of the multi-disciplinary team, challenge poor practice and provide leadership. The presence of these traits was discussed briefly in the nurse educator

focus group where participants described a greater sense of the significance of evidence base and enhanced skills in research methods. This was linked with developing critical thinking noted at an earlier stage than for previous cohorts. Although not measurable per se, these increased critical thinking skills did indicate a change in focus to developing graduateness in the students.

Of significance was the critique offered by student focus group participants regarding clinical practice. During every meeting, participants commented on the standards of care they observed. On many occasions, these standards did not meet with their expectations. Although some were a little parochial, many of the discussions were reasoned and identified the students' abilities to 'think critically' in the context of clinical practice, challenge what they witnessed and carefully consider its impact on them. In other words, they demonstrated elements of graduateness. Another issue raised in the student focus group is worthy of further comment. The participants felt that some educators were reluctant to take questions and ultimately made the students feel stupid for asking them. There is insufficient information available to make a valued judgement; there may have been misinterpretations regarding the response of the educator, or time constraints in the relevant sessions, but the persistent nature of this issue, in the opinion of the students, is a concern. When students are on a programme that is designed to improve their critical and analytical skills, it seems counterproductive and even counterintuitive to stifle questions and refuse to answer them. As Hunter and Arthur (2016) identified, this attitude can negatively impact the student's developing clinical reasoning skills. Hunter and Arthur (2016) noted that where a student nurse felt able to ask questions in clinical practice they were more likely to be seen engaging in clinical reasoning. Where questioning was discouraged, the students completed tasks without clinical reasoning. Whilst the context here was clinical practice rather than the university setting, the programme should be viewed as a whole (an integration of theory and clinical practice) and stifling questions could have a negative impact on the students' developing clinical reasoning skills.

Some AHP educators remained unconvinced that graduate traits were either necessary, relevant, or apparent in nurses/nursing students. There remains a notion that academic ability and a caring, compassionate attitude are mutually exclusive.

There is no evidence to support this, and yet it remains a widely-held belief. Aubeeluck, Stacey and Stupple (2016) describe the, "consequence of developing a professional identity within a culture of anti-intellectualism," (p.105), the result often being a feeling of inadequacy due to the perceived notion that an individual nurse lacks competence or the ability to care; the 'too posh to wash' and 'too clever to care' perspective (Scott, 2004; Young, 2004). Baldwin, Bentley, Langtree and Mills (2014, p.10), writing from an Australian undergraduate nursing perspective state,

> Our search for understanding of graduate attributes and how to apply them to everyday teaching in an undergraduate nursing program led us on our own journey of discovery. It was on this journey that we realised that students, themselves on a journey of learning and endeavouring to establish a professional identity, are following a path where the stones are the steps of knowledge laid down for them by educators.

The challenge for nursing and nurse education would appear to be convincing some that these graduate attributes are necessary, and that the path they build (individually and collectively) for the students is a robust one.

In my role as a personal tutor I met with a final year student in the days before she completed the programme in September 2016. At our first personal tutor meeting three years previously, she had categorically stated that she did not understand why she needed a degree to nurse. We agreed that we would reconsider her opinion at the end of the programme - which we did. She was absolutely convinced that nursing should be a graduate profession and argued that the type and level of work, the need to understand and utilise current evidence and the ability to think critically and construct a reasoned argument were all aspects of the role which now made graduate level preparation a necessity. The feedback from mentors and others in practice that this student had received clearly highlighted that she was an excellent 'practical' student nurse. The best interests of patients were, according to the reports and testimonies from staff, patients/service users and relatives, at the heart of everything that she did – she 'cared'. She finished the programme with a first class honours degree – proving her high level of academic ability too. This is one of many examples which strongly indicate that caring and academic ability are not mutually exclusive.

What is more significant is that this student's experiences convinced her that graduate skills were required for her to fulfil the role of the RN. Undergraduate nursing students are in the unique position of wanting a career in nursing, are students on an undergraduate programme and are working, albeit as students, in twenty-first century healthcare in England. No other group can offer this perspective and their perceptions are vital as nursing begins to manage the increasing numbers of graduates within the profession. Further longitudinal studies are required to investigate the impact that these graduate nurses will have on healthcare practice.

Some of the students referred to their desire to gain a professional qualification and/or professional knowledge. There were no discussions on what this professional knowledge entailed, but the purpose of gaining it was seen as impacting positively on patient/service user care. Andrews (2012) suggests that undergraduate nursing programmes in the UK implemented since the decision to move to an all graduate entry provide the link between graduate skills and professional 'knowhow'. She states, "This to an extent gives nursing an advantage over more traditional disciplines as we have historically developed the professional before we have developed the scholar," (p.848). Nursing needs to develop both simultaneously. The evidence from this case study would indicate that these graduate skills are recognised as significant by the majority of healthcare educators, and are being developed in the students as they progress through the programme.

Willis (2015) argues that more should be expected of the graduate nurse in terms of advanced skills, clinical decision-making and the application of research and innovation. These are graduate attributes and would seem to place emphasis on the development of the *graduate* nurse. In other words, it is the value added by being a graduate that is going to have the greatest impact. This is not to undermine the fundamental aspects of nursing care and the vitally important function of the therapeutic relationship. Indeed, the current study endorsed that these were seen as significant by many of the participants.

6.2.3 Situated learning/social learning theory

Situated learning theory endorses the concept that learning is a social process, dependent on the situation or culture in which it occurs (Brown *et al*., 1989; Lave & Wenger, 1991; Onda, 2011). A major influence on the learning by and development of a student nurse is time spent in clinical practice. A key aspect on the quality of learning is the student's relationship with their mentor (Holland, 2008; Mcilfatrick, 2004; RCN, 2012). Members of the student focus group had mixed experiences across their different clinical settings, not necessarily related to their field of nursing or whether the placement was in primary or secondary care. As Lave and Wenger (1991) argue, through 'legitimate peripheral participation' (LPP) the student/novice learns from the old-timer/expert, and in doing so becomes an accepted member of the culture. Spouse (1998) argues that without effective mentorship, meaningful LPP is impossible. A significant issue for the participants in the student focus group, especially when working in a secondary care setting, was that they felt they spent most of the time working with 'old-timers' who were health care assistants (HCAs) than they did working with 'old-timers' who were RNs. They recognised the need to learn the fundamental aspects of care, but were frustrated when this was at the expense of other aspects of the RNs role, for example, medicines' management. Some of the 'fundamentals of care' roles of a RN can, and are being undertaken by HCAs. It is therefore understandable that students, especially in early placements, work alongside HCAs and learn from them. Role-modelling in that respect should not be limited to only those from the profession the student is following. However, care must be taken that as students progress through the programme and move from peripheral participation to increasingly being recognised as members of the nursing community, they spend less time working alongside HCAs and more time working with RNs. The students soon identified RNs and HCAs who took an interest in them and were willing to invest time in teaching them. This highlights an interesting aspect of LPP in relation to who legitimises the participation. The students chose to work alongside other members of staff, sometimes resulting in the fact that they did not work with their mentor the required 40% of the time (NMC, 2010c). Mentors made the decision as to whether the student had successfully completed the placement, therefore had a crucial role to play in the students' progress on the programme, but it would seem that much of their learning and socialisation was managed by others.

Andrews (2012, p.848) states that, “conceptualised as a process of socialisation, the formation of identity is influenced by the relationship of the individual with their immediate professional community.” Participants in the student focus group had mixed experiences in relation to this formation of identity and socialisation. They recognised the importance of being accepted on to the wards, and how significant learning could not take place until this had been achieved. One participant expressed feelings of being ‘an annoying addition’ to an already busy workload for mentors, another of being ‘out on a limb’ whilst all the RNs were sitting together in the office. On other occasions, the relationship with mentors was much more coherent and constructive. Some felt that they were accepted as members of the healthcare team, and invited to social events, but for one, a key issue was the fact that they were still referred to as ‘the student’ even though they had been working in the clinical area for several weeks. The use of this title rather than their name had a significant negative impact on this student’s sense of belonging. Levett-Jones and Lathlean (2009) discuss the significance of feeling accepted, appreciated and recognised as a member of the healthcare team and not seen as an outsider. The student focus group participants identified a need to work at making a good impression and being accepted. This was particularly the case if the student wanted to work in the specific area once qualified. Lave and Wenger (1991) suggest that the sense of identity and acceptance afforded to the student through effective LPP acts as a motivating factor. Bandura (1971 and 1977) refers to the need in some learners to maintain motivation over a sustained period, especially if the rewards are not immediate. This aspect of a longer-term motivation was apparent in members of the student focus group. As discussed, one key factor in the level of motivation was the alleged/perceived poor practice that they witnessed. There was a real sense that this motivated them to not be like that, to provide better standards of care. Before dismissing these RNs as ‘uncaring’ it is perhaps worth considering the results from the study by Austin, Goble, Leier and Byrne (2009) on compassion fatigue. Although this term was originally used to describe the cultural phenomena of weariness and its impact on empathy in the midst of local, national and international social problems, the term now encompasses the notion of burn out and stress amongst care-giving professions, with nurses amongst those professions particularly at risk (Austin *et al.*, 2009). The study, based in Canada, utilised unstructured interviews with five RNs who had self-reported as

having or having had compassion fatigue. The authors identified six connecting themes, 'running on empty'; 'shielding myself', 'being impotent as a nurse', 'losing balance: It overwhelms everything', 'the kind of nurse I was' and 'trying to survive'. Whether any of the RNs implicated as giving poor standards of care by participants in the current study were suffering from compassion fatigue as described by Austin *et al.* (2009) is not known, but its effect should not be discounted. However, considering the much-publicised failures of care in the UK and the resulting inquiries, there remains much work to be done. The needs of the patients/service users are paramount and any improvements in the standards of care must focus primarily on this. Nevertheless, educational providers must also consider the impact that seeing, and by association being involved in these failures can have on student nurses. Students in the current study expressed a deep desire to improve the standards of care and to not reflect or become accustomed to reduced standards. How long these motivations and desires can be sustained is open to question. Effective role modelling in clinical practice is vital in facilitating professional identity and socialisation (Baldwin *et al.* 2014).

Baldwin *et al.* (2014) argue that academic staff are role models for the students too, not only in relation to what they are being taught, but the way academic staff undertake their professional duties. The perception from members of the student focus group that some academic staff stifled debate and were reluctant to answer questions or provide rationale for their approach would seem to offer a rather negative role model. It is also important to recognise that role models and influential people in the motivations for and attitudes of the nursing students were not just limited to those who may have a recognised, legitimate function, e.g. a mentor or nursing educator. A number of the students discussed the influence of nursing care they had received or seen given to family members as a key influence on their decision to study nursing. One of the focus group members, who had some negative experiences regarding the standards of care she observed in clinical practice, was positively influenced by the care and compassion offered to a relative by a RN.

6.2.4 What is nursing and the role of the Registered Nurse?

Question 31 of the questionnaire distributed to student participants in the current study asked them to write about what they thought the role of the RN from their field of

nursing was. The theme 'therapeutic relationship' which included a sub-theme related to the 'six Cs' (DH & NHS Commissioning Board, 2012) was by far the most significant theme in terms of references to it. This current generation of nursing students do acknowledge the fundamental relationship with the patient/service user, including the verbs to care, practice with compassion, courage, competence, commitment and effective communication, to be of paramount importance. Not only did the students identify the 'six Cs' as verbs, many also recognised them as personal attributes that the RN should have, and some described these attributes in themselves. Recommendation 185 of the Francis Report (2013a) with its focus on the culture of caring highlights the need of nursing education to attract prospective nurses who possess the appropriate values, attitudes and behaviours, and have a motivation to help others. The student participants in this study demonstrated these values, attitudes and behaviours.

The focus on the patient, the interaction between the nurse and the individual patient/service user, family or group is a foundational aspect of the role of the nurse (Mendes *et al.*, 2015, RCN, 2014). Several of the defining attributes identified by Mendes *et al.* (2015) (see Chapter three) were referred to, in broad terms, when student participants in the current study described the role of the nurse from their field. Mendes *et al.* (2015) identify critical thinking and a valuation of the fundamentals of care to patients among the antecedents. This would suggest that the defining attributes of the role and responsibilities of the RN are only truly realised in those who possess critical thinking skills *and* continue to value the fundamental aspects of patient care. Nursing history would suggest that there has been an emphasis placed on the second of these antecedents but that in more recent times critical thinking and other 'graduate attributes' have become more prominent. Nursing as a profession needs to ensure that the pendulum does not swing too far in the direction of aspects such as critical thinking, to the detriment of an appreciation of and involvement in the therapeutic relationship. As Baldwin *et al.* (2014, p.9) suggest,

> Nursing education is a dynamic process aiming to produce graduates who not only fulfil professional registration requirements but who are able to actively participate in the provision of quality nursing care in a range of settings upon graduation.

The student focus group meetings provided participants with an opportunity to discuss their experiences on the programme. There was a general sense that the RNs spent too much time in the office, often completing paperwork, and that most of the fundamentals of care were undertaken by HCAs and the students themselves. The scope of the current study did not allow any 'right of reply' or explanation from the unnamed RNs implicated by these accusations, and it is recognised that there are many factors that impact on the standards of care (Blackman *et al*., 2014). The students also expressed a recognition of the constraints and pressures associated with healthcare practice, and a changing role for the RNs in many clinical settings. Scott (2008), writing from a New Zealand perspective, highlights the suggestion from Dingwall and Allen (2001) (UK) that perhaps in some settings the traditional, altruistic view of nursing care should be re-considered as it is slowly being replaced by 'care by proxy' through a process of 'skill-distribution'. Writing around the same time as Dingwall and Allen, Beck (2000) (USA), identified that, "nursing practice is changing as nurses today manage patient care through others," (p.322). Beck (2000) suggests that the challenge for nurse educators is to identify creative ways in which prospective RNs can still experience the satisfaction and pleasure of helping others that drew them towards the profession in the first place, even if constraints may prevent them from always being directly involved in the care.

Bradshaw (2017) in a paper titled 'What is a nurse?' provides a historical account of nurse training and links this with recommendations from the Francis Report (2013a and 2013b). It is interesting that Bradshaw (2017) largely refers to nurse *training* and not nurse *education*. The inference is that there should be some theoretical content, but that most of the learning should be undertaken in the clinical setting working alongside experienced practitioners. Bradshaw (2017) is somewhat dismissive of claims in the Willis Commission (RCN, 2012) that nurse education cannot be held responsible for the much-publicised failing standards of care. Bradshaw's (2017) paper infers that nurse education *is* implicated in the deteriorating standards of care, highlighting that the problem started in 1986 with the advent of Project 2000. Clearly, there are factors beyond the way student nurses are prepared for their RN role which impact on standards of care, and many of these have political and financial implications at their heart. Significantly, Lord Willis (in his introduction to '*Raising the*

bar', the report submitted on behalf of the Shape of Caring Review, commissioned by Health Education England and the Nursing and Midwifery Council, which he chaired) stated that,

> Inevitably, issues of staff shortages, use of agency staff, bank staff and overseas nurses, and in particular shortages of appropriately trained care staff were constantly brought to my attention. I fully recognise that these issues do impact on high-quality care, as does pay and conditions of service but so does having the right patient focused education and training, appropriate career structures and crucially the shape and nature of the culture within which our registered nurses and care staff deploy their skills and practice.
>
> (Willis, 2015, p.3)

Willis (2015) expressed disappointment in the lack of improvements in key areas such as the development of high-quality mentoring and improved practical (clinical) experiences for students since the RCN (2012) review of nurse education that he also chaired. Nurse education has a vital role to play in what nursing is and what nursing will become in the future, but this role must be seen alongside that of national Government, local care organisations and providers, and the public perceptions and expectations of healthcare in the twenty-first century. Increased demands on healthcare practice are inevitably having an impact on the space and time that a RN can spend mentoring a student nurse, a fact highlighted in the current study. Students' experiences are seemingly compromised *because* of the multifactorial impacts on care delivery. As an advocate of simulation-based learning, I would argue that it has a role to play in pre- and post-registration nursing education and have jointly investigated the impact of simulation on the learner (Hope, Garside & Prescott, 2011), and the skills and competencies required of the educator (Topping *et al.*, 2015). Nonetheless, I would vociferously defend the fact that student nurses must spend a significant amount of their time in clinical practice. However, the learning environment and support that students receive, at least based on their experiences in this study, must improve. It is one thing to say students would benefit from more time in clinical practice, it is quite another to ensure that clinical practice is a safe and appropriate environment in which they can learn high standards of care and best practice. The

constraints (especially, according to the current study, in acute care settings) on a mentor's ability to work alongside a student must also be considered. This relationship is vitally important, and any compromises to that relationship must be carefully studied, especially if prospective student nurses will have to spend some time in clinical practice before applying for their nursing degree (Francis, 2013a).

6.3 Outcomes

The conceptual framework (Figure 6.1) was designed to include key outcomes expected from the undergraduate student nurse on completing the programme and becoming a RN. The outcomes emerged from statements by key stakeholders at the initial announcement of the move to an all graduate entry to nursing, and relevant literature. The student participants in this study had not completed the programme when data was collected and therefore a valid account of the nature of these expected outcomes at point of registration is not available. Nonetheless, conclusions can be drawn on the development of them in the students at the time of data collection.

Critical thinking

Critical thinking is recognised as being one of the key outcomes of graduate education (Girot, 2000a; Kreber, 2014). Critical thinking is complex (Burrell, 2014; Chan, 2013a; Facione & Facione, 2007), but there was significant acceptance across the nurse and AHP educators that critical thinking skills were both necessary in nursing and a fundamental principle of being a graduate. There was universal acceptance amongst the participants in the nurse educator focus group that they had noted improved critical thinking skills in the undergraduate students when compared with previous cohorts. Critical thinking was not formally measured, therefore it is difficult to make any significant generalisations regarding the development of these skills. Nonetheless, as Stake (1995) and Salminen *et al.* (2006) suggest the value of the case study approach lies in the particularity of individual cases, and this aspect of the current study would indicate an increased level of critical thinking amongst the students as a result of being on an undergraduate programme.

Clinical reasoning and decision-making

Lives depend on competent clinical reasoning (Facione & Facione, 2008). Clinical reasoning needs time to develop. Critical thinking is linked with clinical reasoning and decision-making, and the terms may be used synonymously (Hunter & Arthur, 2016). Many of the nurse and AHP educators identified the need for clinical reasoning and decision-making skills in the RN, and therefore a need to develop these in the student nurse. As Hunter and Arthur (2016) argue, the clinical environment, the attitude of and support provided by mentors and others in clinical practice can significantly influence the development of the student's clinical reasoning. Participants in the student focus group described different levels of acceptance and support whilst in clinical practice, but what was apparent across the four meetings was an increase in their confidence. Whilst they may not have referred directly to improving clinical reasoning skills, the improved confidence was based on the fact that they were able to make suggestions regarding the care of patients/service users, which were listened to and acted upon by their mentors. Effective clinical reasoning also requires the foundation of sound clinical knowledge.

Care and compassion

According to Baldwin *et al.* (2014) effective clinical reasoning is dependent on the student's ability to provide holistic care, which in turn requires empathy and compassion. The 'six Cs' (DH & NHS Commissioning Board, 2012) featured heavily, highlighting the need for these attributes and their importance alongside the developing graduate skills. There was also a recognition that having a degree did not guarantee a caring and compassionate attitude any more than not having a degree did. Some student participants recognised these attributes in themselves and provided some justification for their choice of profession – nursing was an obvious choice *because* they were caring and compassionate.

Increased levels of practice and knowledge

The complexities of healthcare were identified by many respondents across the study. There was a recognition that nurses required an increased knowledge base, linked with effective critical thinking to facilitate effective clinical reasoning. The need for

improved leadership skills was also highlighted. Clinical knowledge was not only gained in clinical practice; students valued seminars and simulation sessions.

Inter-professional learning and working

The importance of effective inter-professional working (IPW) was recognised across the student and educator participants in the current study. Some students referred to IPW or collaborative working when describing the role of the RN. Some educators referred to the importance of IPW and how the move to an all graduate entry should facilitate this by providing nursing equity with the other health professions. There were some differences between the participants in the nurse educator and student focus groups in the perceptions of the inter-professional learning (IPL) element of the programme. The educators spoke of the benefits of IPL in terms of learning about each other's role and how it might improve how nursing was perceived by the other professions. The students saw the benefits of IPL, but struggled with its structure, especially in their second year. Concern was expressed by the students regarding the different focus and priorities of IPL in university compared with IPW in clinical practice, especially in relation to shared goals and objectives. Hinting from their own experiences, they expressed frustrations that some members of IPL groups did not engage with the process. A possible solution was suggested, where IPL groups worked through a clinical scenario – with each student contributing in relation to their own clinical background rather than in a more generic way as seemed the case to the participants. Mcilfatrick (2004) argues that IPL needs to be more than students sitting in a classroom together. IPL at the university where the current study was based was not limited to just sitting in a classroom together and did involve working on a project in small IPL groups. However, as discussed during the student focus group, the focus of the projects did not necessarily relate in any direct way with the professional background of all the group members. This led to some frustrations, clearly articulated by one focus group member and probably led to a lack of engagement from some.

6.4 A brief overview

Chapter one on the history of nurse training/education confirmed that the level and type of education that nurses need is controversial. It also highlighted that in many cases, the key divisions were within the nursing profession itself. As far back as the

late nineteenth century and throughout the twentieth century, there were heated debates regarding the level of the 'academic' content (initially in terms of the emphasis placed on the scientific and technical elements) in nurse training/education. These were set, at least initially, against the predominant view that nursing was a vocation and that almost any woman could nurse, essentially by instinct. Nurses needed to be of sound character and be disciplined, restrained and obedient. A religious faith, whilst not a pre-requisite, was viewed as important. The registration of nurses, the development of national standards for training and ultimately the move away from the apprentice-style 'training' to 'education' based in HEIs were all subject to dispute. At the heart of much of the debate was the role of the RN and the training/education needed to fulfil that role. Workforce provision was also seen as vital and student nurses (at least until the move to HEIs) contributed significantly to the hospital workforce. The move to an all graduate entry to nursing was another significant step in the history of nursing and nurse education, and viewed against the background of the previous 140 years, it was not surprising that the move created its own controversy. Chapter two captured some of these arguments in the form of critical debate and concluded that there appeared to be more robust evidence supporting the move than against. Chapter two also discussed the issue of a nurse being both intellectual and compassionate; seen as essential by some and a paradox by others. The two are not mutually exclusive and this study supports the argument that the education system must produce nurses who are both (McKenna *et al.*, 2006; RCN, 2012; Taylor *et al.*, 2010).

The conceptual framework presented in chapter three outlined the influences on and expected outcomes of an undergraduate student nurse. The framework highlighted the multifactorial aspects of this study and recognised that there was not one theoretical perspective that would fully describe its scope. Amongst other concepts, chapter three presented critical discussions on key issues such as 'is nursing a profession?', and the type and level of knowledge required by nurses, presented definitions for nursing and the role of the RN, and examined Social Learning Theory and its contribution to the development of the student nurse.

Chapter four presented some rationale for the case study approach, and the chosen methods of data collection and analysis. Case studies can generate a lot of data (Crowe *et al.*, 2011; Payne *et al.*, 2007; Salminen *et al.*, 2006) and the current study was no exception. Each data set was analysed independently before themes across the whole data corpus were identified. The student questionnaire provided comprehensive data on the participants' attitudes towards nursing, their motivations for starting the programme and what they perceived the role of the RN in their field of nursing to be. The student focus group provided a lot of data on the participants' experiences on the programme. This included a critique of the standards of care observed on clinical placement. Nursing and allied health professional (AHP) educators presented their attitudes towards an all graduate entry to nursing and in doing so, highlighted many of the arguments discussed in Chapter two. Finally, the nurse educator focus group provided clear indication of these participants' attitudes towards the move and their experiences in teaching and supporting students through the first two years of the programme.

6.5 Limitations of the study

The study was based at one English university, and whilst it was argued there would be some representation of other HEIs, nursing educators and students the results must be viewed within this constraint. The initial low response from the student questionnaire was a potential limitation. This was 'managed' by repeating the distribution of the questionnaire, using direct hand out rather than electronic links via email. Analysis was only undertaken on the data obtained from this final distribution.

The self-reporting nature of the questionnaires means that respondents may have provided socially acceptable replies. For example, the students completed the questionnaire in a lecture/classroom setting and there may have been an element of discussion about responses amongst some before the questionnaires were returned. The low numbers of participants in both the student and nurse educator focus groups should also be seen as a limitation. In addition, the timing of the final distribution of this questionnaire, eighteen months into the programme meant that students were reflecting on their historical motivations for wanting to nurse. Their responses may have been modified due to their experiences on the programme.

The initial intention for this study was to also investigate the attitudes and experiences of the move to an all graduate entry to nursing of current mentors working in clinical areas that students from the university where the study was based attend. It was concluded early in the study that the inclusion of this group of participants would produce an unmanageable amount of data in relation to the scope of the study. Participants in the student focus group were able to provide meaningful data on their experiences working alongside mentors in clinical practice but this remains a limitation of the study as potentially significant voices were not heard directly. However, the value of this study is in the voices heard, especially that of the students based at one university. Significantly too, was the perspective of AHP educators at the university. Healthcare practice is multi-professional and the perspective of other AHPs should be considered. However, a limitation of the study was the low number of participants from each allied health profession. The study did not set out to identify any generalizability of these attitudes and experiences, but to critically examine this one case. The themes that have emerged from the study are not intended to have broad generalizability either, but there are issues raised that are of interest to nurse education and nursing practice, especially in the United Kingdom (UK).

The six-phase approach to thematic analysis devised by Braun and Clarke (2006) in their paper titled '*Using thematic analysis in psychology*' was used. The paper clearly emphasises the use of the framework in a particular subject area and the authors provide examples from their own studies to emphasis the key points. However, I felt that the principles discussed in the paper were generic enough and the stages described in sufficient detail to be appropriately applied to the current study. Nonetheless, it is accepted that there are several other approaches to thematic analysis, some of which would be described as more "kudos-bearing" (Braun and Clarke, 2006, p.97).

6.6 Some reflections

The motivation to investigate this issue was birthed reading the general and nursing press following the announcement of the move to an all graduate entry to nursing in England. I remain passionate about nursing and about my role in preparing the Registered Nurses of the future.

The initial low response rate for the student questionnaire was very disappointing, but my adoption of a different approach led to a significant increase in responses. Similarly, the number of students and educators who agreed to participate in the relevant focus groups was disappointing. I am a pragmatist and did not view these as setbacks, but used them as a learning experience in project management. As a result, I have learnt a great deal in managing a project of this size. The different approaches to data analysis were new to me and I have developed as a researcher by undertaking such analysis.

I found that a real challenge was the breadth of the subject of nursing education and the scope of studies and papers written on various aspects of it. The need was to remain focused on the purpose of the study and its aims and objectives. The study was not an evaluation of the nursing degree programme at one university, nor was it an investigation into what should be included in an undergraduate nursing curriculum, which styles/approaches to teaching work best or what may constitute an effective clinical experience. These are important issues and more emphasis could easily have been applied to each one in this study, but they were not the main focus of the study. I am confident that I have got the balance about right.

As the move to an all graduate entry to nursing in England was new at the time when the study commenced, any study investigating aspects of the move would, by definition, generate new, original knowledge. Even if many of the issues discussed in this study had been investigated before, this was a different context. In addition, the purpose of the case study approach is to investigate a particular 'case' or example and this had never been done at the particular institution where the study was based.

6.7 Conclusions and recommendations

A clear and consistent message from the student questionnaire was that their reasons for wanting to pursue a career in nursing reflected those held by nurses over recent decades and across many international settings. The altruistic reasons were dominant in their motivations for wanting to pursue a career in nursing. Crucially, the student focus group indicated that the participants' experiences in clinical practice were not directly influenced by the fact that they were undergraduate students; the matter was

not discussed. Their experiences *were* affected, both positively and negatively by the standards of care they observed, the quality of mentorship and by issues related to belongingness and socialisation that have been on-going since the move from Schools of Nursing to HEIs. The relationship between student and mentor remains crucial, and nursing must continue to invest in and develop this vital role. The increasing complexities of healthcare may challenge the time available to invest in the student/mentor relationship, but its significance must not be overlooked. Nursing students require mentorship from experienced nurses who reinforce the values of nursing and promote the role of the RN.

This study has presented evidence to indicate the positive impact that graduate nurses, with it is argued improved critical thinking, clinical reasoning and leadership skills can have. The recognition of the importance of graduate attributes, highlighted by educators and many of the students themselves, contribute to the confirmation that the move to an all graduate entry was justified. This study also confirms that nursing students do recognise the care and compassion virtues underpinning nursing that Francis (2013a) and Bradshaw (2017) refer to. This is a significant outcome considering much of what has been written in some general and nursing press relating to 'too posh to wash' and 'too clever to care' since the announcement of the move to an all graduate entry to nursing. This study adds to nursing knowledge by confirming that graduate status in nursing is justified if nursing desires caring and compassionate individuals who also possess the important graduate attributes required in 21 century healthcare.

No study based in England on the move to an all graduate entry to nursing had examined the views of the students themselves and in light of the much publicised accusations that they would be 'too posh to wash' and 'too clever to care', their enthusiasm for nursing, their motivations for starting the programme, and perhaps most importantly of all, the altruism and genuine desire to care, with the therapeutic relationship with the patients/family at the heart of everything they wanted to do is, in the context of the all graduate entry original and provides important evidence to defend these students against such accusations. The accusations of 'too posh to wash' and 'too clever to care' should be replaced with a far more positive view of the graduate

nurse. There remains some 'hearts and minds' that need to be won in relation to the fact that nurses can be intelligent and caring. This study makes a positive contribution towards that aim. This message should not be limited to just the nursing profession, through the media of nursing journals, but to the wider general public too through the use, for example of the University website.

Nursing educators are gatekeepers to the nursing profession and play a significant role in the development and socialisation of the student nurse. Their attitudes and opinions matter and should not be underestimated. Some concerns regarding the move to an all graduate entry to nursing were expressed by nurse and AHP educators. However, there was clear recognition of the complexities of healthcare in the twenty-first century and how nurse education needed to prepare nurses for their comprehensive role. In recognising this, there was almost universal support that nurses required many of the graduate attributes/skills outlined in Chapter three. To reword Betts' (2006) suggestion that the goal of nurse education is to produce thinkers who can practice rather than practitioners who can think, perhaps the move to graduate entry has introduced the debate as to whether the goal of nurse education is to produce nurses who are graduates or graduates who happen to be nurses.

The students' concerns about some educators being reluctant to take questions must be addressed. The outcomes of the study will be disseminated to academic colleagues at the university where the study was based, and this aspect will be included. In addition, these outcomes will be considered as future curricula are developed. The participants in the student focus group raised concerns about the standards of care that they observed in clinical practice. Students were made aware of the 'escalating concerns policy' agreed between the university where the study was based and the various care organisations where students undertake clinical placement. The availability and rationale for this policy need to be further emphasised and its use in such circumstances encouraged.

The use of evidence base was viewed as an essential graduate attribute by most of the nursing and AHP educators and was identified by student participants as an aspect of the RNs role. Nursing must continue to develop its own, distinctive knowledge base.

From a UK perspective, the nursing profession should be optimistic that the current generation of student nurses will, when registered, be better equipped to drive the standards of the research agenda and develop the knowledge-base for nursing further. Unlike many of their predecessors, they have been immersed in critical thinking and clinical reasoning throughout their pre-registration programmes, have had research methodologies taught to them by academics who hold doctorates and have publication records. Many will have undertaken either empirical study or a systematic review as part of their studies; in short, they will be *graduates*. Nursing, has a relatively short academic history, but seems to be compared alongside professions with an academic history that spans hundreds of years. Unsurprisingly, the comparisons are not always favourable. Research in nursing, including doctorate level studies, leading to a strengthening of the evidence base for clinical practice must be encouraged.

Nursing as a vocation was discussed by one nurse educator and one AHP educator in the study. The term only appeared in one student response too. However, the notion of a vocational element to the students' motivations for studying nursing was apparent in some responses. This study confirms that these motivations have not been lost as nursing has become more 'academic'. The study supports the move to an all graduate entry to nursing and confirms that nurse educators and mentors continue to have a pivotal role in the development of the student nurse. The altruistic motivations to care for others remain prominent amongst nursing students. A nursing workforce educated to graduate level, like their allied health professional colleagues, is better equipped to manage the increasing complexities of healthcare. There is little or no evidence to indicate that graduate nurses are any less caring and compassionate than their non-graduate colleagues, yet it still appears that the falling standards of care are blamed on the type and level of pre-registration nursing education. Nursing regulators, unions, educators, healthcare providers, and the general public must carefully consider what they expect the role of the RN to be and how that role may change over the next ten to fifteen years. The impact of the introduction of Nursing Associates (Health Education England (HEE), 2016) and the nursing degree apprenticeship programme (DH, 2016b) should be considered alongside this review. Students apply for pre-registration nursing because they want to nurse; to care for and make a difference in other people's lives, and this indicates that they will not be 'too

posh to wash' or 'too clever to care'. Graduate abilities will have a positive impact on their role as RNs. The desire and ability to 'care' and be a student nurse on an undergraduate programme are not mutually exclusive.

This study has investigated the move to an all graduate entry to nursing in England based on the attitude and experiences of student nurses and health professional educators at one English university. The student participants in the study are now Registered Nurses. Further longitudinal studies investigating their transition into the RN role and the strengths and limitations of individual curricula and Nursing and Midwifery Council (NMC) standards in preparing them for the graduate RN role are recommended. The NMC are in the latter stages of a consultation exercise regarding the development of new standards for pre-registration nursing education and the competencies expected from the graduate nurse (Macleod Clarke, 2016; NMC, 2016). The NMC (2016) recognise the many changes that have occurred in healthcare since the previous standards were published in 2010 (NMC, 2010c). As these standards are agreed and implemented, further work is required in confirming the positive outcomes of an all graduate entry to nursing. The values of nursing may not have changed, but in many respects the role of the RN has. This evolving role requires greater graduate abilities than, it could be argued, were necessary in the past. What is required is a serious debate on what the role of the RN is in England in the twenty-first century, and how nursing students can best be prepared for that role.

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Appendix 1: Nurse educator questionnaire

Please indicate by placing a ✓ in the appropriate box your opinions on the following statements. Please indicate whether you strongly disagree, disagree, are neutral, agree or strongly agree with each statement.

Alternatively you also have the option to indicate 'don't know' or 'prefer not to answer'

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know	Prefer not to answer
1. The move to all graduate entry for nursing is a necessity to deliver healthcare in the 21st century.	☐	☐	☐	☐	☐	☐	☐
2. Nursing is a profession that requires highly knowledgeable and competent individuals.	☐	☐	☐	☐	☐	☐	☐
3. Nurses, like colleagues in Occupational Therapy, Physiotherapy and Radiography should be educated to degree level.	☐	☐	☐	☐	☐	☐	☐
4. Nursing is a vocation.	☐	☐	☐	☐	☐	☐	☐
5. A short term technical training is all that is required to become a Registered Nurse.	☐	☐	☐	☐	☐	☐	☐
6. Nursing has lost sight of its true aims.	☐	☐	☐	☐	☐	☐	☐
7. All graduate entry will exclude some excellent Candidates, who would make great nurses, from entering the profession.	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know	Prefer not to answer
8. Nursing needs individuals who have the skills and knowledge to undertake high levels of clinical decision making.	☐	☐	☐	☐	☐	☐	☐
9. An all graduate entry into nursing is not going to encourage more people into the profession.	☐	☐	☐	☐	☐	☐	☐
10. Academic achievement and safe, compassionate care are not mutually exclusive.	☐	☐	☐	☐	☐	☐	☐
11. The only thing that having a degree will do is widen the gap between those people doing the actual nursing on the wards (i.e. the health care support staff) and the 'qualified' nurses.	☐	☐	☐	☐	☐	☐	☐
12. Nurses should be judged on their ability to do the job and not on their academic achievements.	☐	☐	☐	☐	☐	☐	☐
13. Nursing as a profession cannot develop and evolve without degree level education.	☐	☐	☐	☐	☐	☐	☐
14. A degree cannot enable a nurse to be compassionate to a patient.	☐	☐	☐	☐	☐	☐	☐
15. Degrees will take nurses even further away from the bedside.	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know	Prefer not to answer
16. Greater academic knowledge will help nurses care for their patients at a higher level.	☐	☐	☐	☐	☐	☐	☐
17. The degree should only be made mandatory after completing the diploma programme and gaining some post-qualification experience.	☐	☐	☐	☐	☐	☐	☐
18. An all graduate entry will exclude many mature students who would make excellent nurses.	☐	☐	☐	☐	☐	☐	☐
19. Nursing is not simply the carrying out of uncomplicated tasks under the direction of others.	☐	☐	☐	☐	☐	☐	☐
20. Moving to an all graduate entry is the best thing to ever happen to Nursing.	☐	☐	☐	☐	☐	☐	☐

21. Please add your own views on the move to all graduate entry to nursing. Please continue overleaf if required.

22. Which field of nursing best describes your main area of work?

Adult ☐

Child ☐

Learning Disabilities ☐

Mental Health ☐

23. How many years clinical experience (post qualification) did you have prior to moving into HE?

_____

24. How many years have you worked in HE?

_____

25. What is your gender?

Female ☐

Male ☐

Prefer not to answer ☐

Thank you for completing this questionnaire.

Appendix 2: Student questionnaire

Please indicate by placing a ✓ in the appropriate box your opinions on the following statements. Please indicate whether you strongly disagree, disagree, are neutral, agree or strongly agree with each statement.

Alternatively you also have the option to indicate 'don't know' or 'prefer not to answer'

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know	Prefer not to answer
1. Nurses are advocates for the patients/clients.	☐	☐	☐	☐	☐	☐	☐
2. Nurses protect patients/clients in the healthcare system.	☐	☐	☐	☐	☐	☐	☐
3. Nurses participate in the development of health care policies.	☐	☐	☐	☐	☐	☐	☐
4. Nurses should wear a uniform in order to be identified.	☐	☐	☐	☐	☐	☐	☐
5. Nurses act as 'resource persons' for individuals with health problems.	☐	☐	☐	☐	☐	☐	☐
6. Nurses in general are kind, compassionate human beings.	☐	☐	☐	☐	☐	☐	☐
7. It takes intelligence to be a nurse.	☐	☐	☐	☐	☐	☐	☐
8. The service given by nurses is as important as that given by doctors.	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know	Prefer not to answer
9. Everyone would benefit if nurses spent less time in the university and more time in clinical practice.	☐	☐	☐	☐	☐	☐	☐
10. Nurses integrate health teaching into their practice.	☐	☐	☐	☐	☐	☐	☐
11. Research is vital to nursing as a profession.	☐	☐	☐	☐	☐	☐	☐
12. Nurses should be politically active.	☐	☐	☐	☐	☐	☐	☐
13. Nurses are capable of independent practice.	☐	☐	☐	☐	☐	☐	☐
14. Nurses speak out about inadequate working conditions.	☐	☐	☐	☐	☐	☐	☐
15. Nurses are compensated sufficiently for their work by the knowledge that they are helping people.	☐	☐	☐	☐	☐	☐	☐
16. Nurses should have a right to strike.	☐	☐	☐	☐	☐	☐	☐
17. Nurses follow the doctor's orders without question.	☐	☐	☐	☐	☐	☐	☐
18. Men make good nurses.	☐	☐	☐	☐	☐	☐	☐
19. Many nurses who are seeking higher degrees would really rather be doctors.	☐	☐	☐	☐	☐	☐	☐
20. Nursing is exciting.	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't know	Prefer not to answer
21. Nurses incorporate research findings into their clinical practice.	☐	☐	☐	☐	☐	☐	☐
22. The major goal of nursing research is to improve patient care.	☐	☐	☐	☐	☐	☐	☐
23. Nurses are adequately paid for the work they do.	☐	☐	☐	☐	☐	☐	☐
24. Nurses value time at the bedside caring for patients/clients.	☐	☐	☐	☐	☐	☐	☐
25. Nurses should have a degree for entrance into practice.	☐	☐	☐	☐	☐	☐	☐
26. Nurses with higher degrees make important contributions to patient/client care.	☐	☐	☐	☐	☐	☐	☐
27. Nursing is a respected profession.	☐	☐	☐	☐	☐	☐	☐
28. Nurses consistently update their practice in relation to current health trends.	☐	☐	☐	☐	☐	☐	☐
29. Nurses feel good about what they do.	☐	☐	☐	☐	☐	☐	☐

30. Please write about why you wanted to become a nurse.

31. Please write about what you think is the role of the qualified nurse in your particular field of nursing.

32. Which field of nursing are you studying?

Adult ☐

Child ☐

Learning Disabilities ☐

Mental Health ☐

33. What is your highest academic qualification?

GCSE/'O levels' ☐

A levels ☐

NVQ (Please state level) _____ ☐

BTEC National Diploma/Advanced Diploma ☐

Diploma ☐

First Degree ☐

Post-graduate certificate ☐

Post-graduate Diploma ☐

Master's Degree ☐

Doctorate ☐

Other (please state) ☐

_____

Prefer not to answer ☐

34. Do you have any previous health care experience?

Yes ☐

No ☐

Prefer not to answer ☐

If Yes please provide brief details:

35. How old are you? _____

Prefer not to answer ☐

36. What is your Gender?

Female ☐

Male ☐

Prefer not to answer ☐

Thank you for completing this questionnaire